Governance of Teaching Hospitals

Turmoil at Penn and Hopkins

JOHN A. KASTOR, M.D.

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Turmoil at Penn and Hopkins

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For Sam
and, as always,
for Mae

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Preface

In this book I investigate how the leaders of the University of Pennsylvania and the Johns Hopkins University, two of the most renowned American universities, responded to the pressures agitating their academic medical centers by changing the systems governing their institutions.

I began this work by reviewing all the relevant material on the governance of academic medical centers that I could find in our library and through the Internet. Although there was dishearteningly little that applied, this shortage helped to convince me that the study might prove useful. Consequently most of the data on which conclusions could be based had to be developed from primary sources. To do this, I employed the same technique used in my previous book on teaching hospital mergers[1]—interviewing as many people as possible who had information relevant to the governance debate at Penn, Hopkins, and elsewhere. I spoke with 317 people—158 at Penn, 105 at Hopkins, and 54 at other institutions. Most of the interviews were conducted from April 2000 to June 2002, except for a few that reported particularly relevant recent events. They were carried out in the offices of the interviewees, less frequently by telephone or e-mail.

Each person interviewed received a draft of the text that I had written about our conversation for corrections and revisions. With few exceptions, each interviewee responded promptly with useful comments and revisions that saved me from making more mistakes than the manuscript may still contain. I then rewrote the text to include all their corrections and most of their revisions. Some people I spoke with did not want to be directly associated with particular quotations, and I removed the references in these cases. I added, often as footnotes, comments that conflicted from what I had learned from others.

I thank all the interviewees for their courtesy, for the information they supplied, and for their candor. Without their cooperation, this study could not

have been conducted. For their helpful advice, I thank those who read and commented on some or all of the chapters: Introduction—Robert Dickler; Penn—Robert Barchi, Robert Burns, Duncan Van Dusen, Karl Engelman, John Fry, Sheldon Hackney, William Kelley, Arnold Relman, Judith Rodin, Lewis Rowland, and Donald Silberberg; Hopkins—David Blake, James Block, William Brody, George Bunting, Elaine Freeman, Barbara Hill, Michael Johns, Richard Johns, Guy McKhann, Edward Miller, Morris Offit, William Richardson, Joann Rodgers, Richard Ross, and Christine White; and for the concluding chapter—Thomas Detre, Robert Dickler, Edward Holmes, Gerald Levy, and Kenneth Shine.

Barbara Williams was particularly helpful arranging interviews at Penn, and I thank her for her help. At the Johns Hopkins University Press, I thank medical editor Wendy Harris, who sent me the happy news that the Press would be publishing the book and skillfully shepherded it through the stages leading to its appearance. I also thank Maria denBoer, who expertly edited the copy, Becky Hornyak for preparing the index, and Tom Roche and Courtney Bond, the production editors. As she has done for each of my books, Phyllis Farrell checked my review of the proofs and, as usual, found several mistakes I had overlooked. Thank you, Phyllis. Rebecca Harmon and John Shea from the University of Pennsylvania and Nancy McCall from Johns Hopkins University helped greatly in assembling the photographs. I am deeply obliged to Gert Brieger for his continuing encouragement and many useful suggestions and to William Henrich for his valuable support.

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CHAPTER ONE

Introduction

There is a well-worn phrase, so familiar to most observers of American academic medical centers that it has probably reached the status of a cliché: "If you've seen one medical school, you've seen one medical school."[1] Although it is true that the structure and culture of these institutions vary widely, there is also much that is similar among them.

For example, every medical school must relate to a hospital to teach its students and graduate trainees, conduct clinical research, and provide its clinical faculty with the means of practicing their profession. What differs, school to school, is the structure of that relationship. The medical school may own the hospital, the hospital may own the medical school, or neither may own the other. The school, through the dean or another senior officer, may control the hospital, or, as is more common, the hospital's leaders may not report to any officer of the medical school or the university. And then, to complicate matters even further, the states, or, in one case, the federal government, may own the hospital, the medical school, or both.

Before describing the events that drove two of our most distinguished academic medical centers, the University of Pennsylvania and Johns Hopkins

University and Hospital, to attempt to change their governance, let me sketch the governmental landscape of all American medical schools and their teaching hospitals.

Governance of American Academic Medical Centers

Of the 125 American medical schools surveyed for this study (see appendix 1), governments—states in all cases except for the federal Uniformed Services University of the Health Sciences (USUHS)—own 60 percent.[2] Private, not-for-profit corporations own the rest. In only 14 schools, 2 private and 12 state-owned, do the senior officers of the hospitals report to deans. In each of the 14, except at Johns Hopkins for reasons that will be described in chapters 6 and 7, the same entity owns both the hospital and school. The arrangement in which one person heads both the medical school and the principal teaching hospital is seen even less often.

In several academic medical centers in which one entity owns both the medical school and the hospital, the dean and the hospital CEO report to a senior university officer.* In the most frequent relationship, however, the medical schools and their principal teaching hospitals are governed by different entities. This arrangement applies to 78 percent of private schools and 61 percent of government-owned schools. In this scenario, no university officer directly controls the teaching hospital. The hospital chief executives hold their jobs at the pleasure of their boards or authorities. Academic officers can exercise some influence officially through elected, ex officio, or legislated seats on hospital boards of trustees and informally through successful working relationships with hospital executives.

In recent decades, the governance of many teaching hospitals affiliated with state-owned schools has changed. Formerly owned by states with their chief executives often responsible to senior medical officers on the campus, these hospitals acquired corporate independence to:[3]

— remove themselves from the bureaucracy of state-university ownership with, among other restrictions, its civil service employment policies that are unsuitable for hospitals

* Academic medical centers use many titles for their senior medical officers, such as chancellor, vice-chancellor, executive vice-chancellor, president, vice-president, senior vice-president, executive vice-president, provost, vice-provost, and senior vice-provost. Often a phrase such as "for medical affairs" or "for health affairs" is appended.

— negotiate more successfully for the purchase of equipment and supplies
— improve incentives for collecting money and reducing costs
— borrow funds for capital improvements in the private market

These conversions occurred in what has been called "two waves." During the 1970s and 1980s, the hospitals and health systems changed their governance to operate more efficiently and effectively than state governmental structures allowed. In the 1990s, strategies to assure corporate survival drove the changes as universities tried to prevent current or projected losses from their hospitals and health systems from depleting their resources. Health system expenses often account for half of university budgets. This would become the principal concern motivating the trustees of the University of Pennsylvania to find some way of ejecting their money-losing health system from university ownership. In state-owned schools, the combined structure tended to continue where the governance was so structured to allow the medical centers to operate relatively independently of the parent university under regulations more suitable for the management of a hospital than for a department of, for example, English.

Leaders of medical schools whose teaching hospitals were seeking separate governance, quite understandably, regretted the potential loss of their authority over the hospitals.[3] Whereas previously the dean or medical center chief executive could unilaterally direct surpluses generated by the hospital to support academic programs, these transfers now required negotiations between the leaders of the hospitals and the medical schools, neither of whom reported to the other. When controversy between the leaders of independently owned hospitals and medical schools developed, the effects could devastate morale and progress, as happened at Hopkins during the mid-1990s.

Changes in Governance

The governance of academic medical centers seldom changes, but, when it does, what forces cause such alterations? Are, for example, the inherent structures of the institutions, changes in health care delivery and financing, or conflicts among leading personalities most important? To what extent do the permutations of governance among schools and their principal teaching hos-

pitals affect how well the school and its principal teaching hospital conduct their work? These and related questions prompted this study.

The book consists of this introductory chapter, six chapters on the case reports, and a concluding chapter.* I have separated the material on Penn into four chapters roughly divided by their temporal relationship to the presence and activities of Dr. William Kelley, the leader of its academic medical center from 1989 to 2000. It was the effects of his decisions that drove the university to attempt to change its governance. In the first of the two Hopkins chapters, I detail the structure and function of the medical school and hospital when separately governed. The second chapter on Hopkins describes how conflicts within the institution during the mid-1990s forced a fundamental change in the governance of this leading medical organization. In the chapters on Penn and Hopkins, I reported what I was told without introducing much editorial comment. An analysis of what I learned appears in the concluding chapter.

* See appendix 2 for names and titles of each of the people interviewed for this study.

CHAPTER TWO

Before Kelley

The University of Pennsylvania* appointed Dr. William N. Kelley dean of its school of medicine and leader of its medical center on August 2, 1989, and discharged him from these responsibilities on February 16, 2000. During the intervening ten and a half years, the Kelley administration formed a health system; bought three hospitals and the practices of 270 primary care physicians; constructed two medical school research buildings and one new hospital building; equipped several suburban practice facilities; renovated one million square feet of space in the medical school and the principal teaching hospital; appointed new chairs for each basic science department (one twice) and all but three of the clinical departments (one twice); created twelve institutes and centers; revised the curriculum for medical students; and helped recruit so many productive investigators that the research conducted by the medical faculty won a level of support from the National Institutes of Health (NIH) surpassed only by the medical enterprises at Harvard and Johns Hopkins

* *Disclosure:* The author received his bachelor's degree from the University of Pennsylvania and was a member of its medical faculty from 1969 to 1983.

universities. However, during the final three years of his reign, the University of Pennsylvania Health System lost $300 million; one of its most prized research programs, a particular favorite of Kelley, came under national scrutiny; and William Kelley lost his job.

To receive the bad news, Kelley walked north across Spruce Street to the College Hall office of Dr. Judith Rodin, president of the University of Pennsylvania. He thereby crossed the Philadelphia street which, geographically and symbolically, has long separated Penn's medical establishment from much of the rest of the parent university which, periodically, has had a troubled relationship with its distinguished medical school and hospital.

History of the University of Pennsylvania and Its Medical School

Spruce Street begins at the Delaware River as do all the original east-west thoroughfares of Philadelphia. Traveling west, one passes, at the corner of 8th Street, the Pennsylvania Hospital, the country's oldest, long associated with the university and recently added to Kelley's health system. Several blocks west of Broad (14th) Street, Spruce becomes Philadelphia's version of Harley Street where, like their London counterparts, Philadelphia consultants formerly practiced medicine in private homes. The street then temporarily ends at the Schuylkill River and reappears in West Philadelphia, where the university moved after outgrowing the buildings in which it operated during its first century.

Penn claims its origin in the "College, Academy, and Charity School of Philadelphia," founded through the efforts of Benjamin Franklin, among others.[1,2*] In 1765, Dr. John Morgan (1733–1789), who had received his A.B. degree at the college's first commencement in 1757, returned from Europe with an Edinburgh M.D. and started teaching as the college's original medical professor, thereby inaugurating the first medical school in the American colonies.[3,4]

For its first hundred years, the medical faculty taught students at the Pennsylvania Hospital, five city blocks from the second location of the college's buildings. However, when the university moved to West Philadelphia after the

* Penn calls 1740 its founding date; this is the year that an educational trust, eventually incorporated into the university, was established. Scholars find this a debatable choice[1] since teaching did not begin for eleven years. Clinging to 1740, however, allows Penn to describe itself as the nation's fourth oldest university after Harvard (1636), The College of William and Mary (1693), and Yale (1701) and senior to Princeton (1746).

Civil War, the two and a half miles to its old teaching hospital led medical school leaders to create a unique facility on the new campus, the Hospital of the University of Pennsylvania. In a conflict familiar to fund-raisers throughout academia, Provost Charles J. Stillé* opposed building the hospital, an effort led by Dr. William Pepper Jr., because Stillé was trying to raise money at the same time for the university's endowment and other buildings.[5]† Stillé, however, could not veto what Pepper and his colleagues wished to do since his office had no direct control over the departments of medicine or law. In effect, the executive officer of the arts faculty alone, Stillé, an historian, was not even a member of the board of trustees nor was he expected to attend the trustees' meetings. The medical professors who ran their school reported directly to the trustees, who usually acted as the medical professors recommended in such important decisions as the appointments of faculty members. Ironically, when Stillé resigned the provostship in 1880, his successor was Pepper who, while retaining a medicine professorship and his private medical practice, now directed most of the university departments.

Initially, the trustees planned to house the hospital in the new Medical Hall,‡ which had been designed for the medical school. Some, however, feared that this solution would lead to the hospital's dominating the school. The minutes of one of their meetings at the time stated:[6]

> The very name of the school would probably be lost in that of the Hospital as in the case of all the schools thus constituted, as Guy's Hospital in London and Bellevue Hospital in New York. Nothing would be more distasteful to those interested in the . . . grand old medical school, known throughout the world as that of the University of Pennsylvania, than to hear substituted for it the name of University Hospital School.

* Provost had been the title of the senior university officer from the founding.

† Charles Stillé was the brother of the senior medical professor, Dr. Alfred Stillé, an example of the intertwining family relationships that were to characterize university, particularly medical, leadership until the middle of the twentieth century. The senior chair of medicine passed through several generations of one family, famous in Penn's medical history. Dr. William Pepper Jr., provost of the university (1881–1894) as well as the senior professor of medicine, was the son and namesake of the senior professor in the 1860s. Provost Pepper's son-in-law, Dr. Alfred Stengel, and, subsequently, his younger son, Dr. Oliver Hazard Perry Pepper, would both hold the leading chairs of medicine. Provost Pepper's older son, Dr. William Pepper III, would become the longest-serving dean in the history of the school (1912–1945) and sign the diploma of his son, Dr. F. Sergeant Pepper.

‡ Still standing on the Penn campus as Logan Hall, but assigned to departments other than those of the medical school.

Consequently, the trustees chose a separate site for their hospital on the south side of Spruce Street between 34th and 36th streets and constructed a building in the Gothic-revival style with the green serpentine stone selected for the other university buildings then rising on the new campus. The Hospital of the University of Pennsylvania, now familiarly called HUP, faced College Hall to the north, the home of the other university departments. Of the four original buildings put up during the 1870s, three housed medical school activities, attesting to the dominance of medicine in the university's life.* For decades, as many as three times as many students graduated each year from the medical school as from the college.[7]

At its founding, the university trustees decreed that the hospital be directed by a board of managers consisting of two trustees, the seven professors of the medical faculty, three graduates elected by the alumni, and three contributors to the Hospital Fund. To staff the hospital, the trustees created "Clinical Professors of the Hospital of the University of Pennsylvania," practicing doctors who, to prevent diluting the authority of the university professors and decreasing the fees the students paid them,[5]† were not appointed members of the medical school faculty.

With the dedication of HUP's central unit for the staff and students and the first of three wings for patients on June 4, 1874, Pennsylvania became the first American university to have built its own teaching hospital, unlike such well-known, contemporary East Coast medical schools as Harvard in Boston, the College of Physicians and Surgeons (later Columbia University's medical school) in New York City, and Johns Hopkins in Baltimore when the hospital that shared its name opened in 1889.‡ These institutions, among others, trained their students in hospitals incorporated as separate institutions

* At the beginning of the twentieth century, the medical school moved to new laboratories south of Spruce Street and west of HUP, where the school would build all its future facilities.

† From the founding of the school until the university assumed the compensation of the medical faculty in the late nineteenth century, the professors earned their income for teaching from fees paid directly to them by the students who attended their lectures. The creation of the hospital professors represented what George W. Corner, the author of the definitive history of the first 200 years of the medical school, calls "the last gasp of the dying fee system as well as the old, seven-man control (amounting practically to ownership) of the medical school [by the senior professors] through personal influence on the trustees."[5]

‡ The University of Michigan claims precedence as the first to *own* its own teaching hospital, a former professor's house that the university converted into a hospital in 1869, nineteen years after Michigan's medical school had been founded.[8,8a]

and operated by different boards of trustees than those that directed the universities with which they were associated. HUP,* however, was, from its beginning, very much a creature of the university and not an independent corporate entity with its own trustees.

Toward the end of the twentieth century, owning a teaching hospital was becoming an increasingly complicated burden for its parent university. The administrative and financial differences continuously grew. For example, the workweek was forty hours at HUP, thirty-five hours at the university. The hospital had sizeable bad debts, changing bureaucratic regulations, and reimbursement, tribulations spared the rest of the university. Despite operating as one corporate entity, each had separate and different management structures. The university leaders began to question the ability of the hospital's executives to manage their immense responsibility which, together with the other parts of Penn's medical enterprise, accounted for more than half of the university's budget.[9]†

The Gellhorn and Stemmler Years

For decades preceding the arrival of William Kelley in Philadelphia, the director of HUP reported to a committee of the university board of trustees chaired by a series of powerful laymen, an arrangement which, according to an emeritus professor of medicine who remembers the time well, "bypassed the president."[10]‡ In the late 1950s, university president Gaylord Harnwell, a physicist, tried to address this dilemma by assigning primary responsibility for the hospitals to the vice-president for health affairs, a physician. "Harnwell put himself on the line for this," remembered Dr. Jonathan Rhoads, the longtime chairman of surgery and a leader in the medical school and in Philadelphia and American medicine for decades, who was provost of the university from

* Also known by its friends and critics as the "Hospital of Undeserved Prestige," the "Hospital of Unlimited Pride," etc.

† Over the years, university officials at Penn have feared that their university would become "Hopkinized," that the medical center would so dominate the university in size, finance, and attention by the public and the trustees that the nonmedical programs would suffer as they had heard was the case at Johns Hopkins University.[5] Whether or not this is so in Baltimore, the perception would be raised whenever the gorilla south of Spruce Street started to roar.

‡ For much of the information in this section, I am indebted to the precise and voluminous memory about Pennsylvaniana of Duncan Van Dusen, who has served as an officer of the university for more than thirty years (despite having received his bachelor's degree from Princeton).[11]

1956 to 1959 when this change occurred.[11,12]* Harnwell, it was said at the time, threatened to resign the Penn presidency if the HUP leadership did not report functionally to the senior university administration.[10] Despite this modification, however, the committee, and particularly its chairmen, continued to exercise significant influence on the affairs of the hospital.[11]

In the second half of the 1960s, Penn's medical school needed a new dean. The man chosen, Dr. Alfred Gellhorn from New York, would bring to the historic University of Pennsylvania school of medicine several concepts with which it was unfamiliar. Gellhorn insisted, as a prerequisite for taking the job, that Penn's hospitals become his direct responsibility. His previous experience at the Columbia-Presbyterian Medical Center had shown him that the hospital, when separately governed, could dominate the affairs of the medical center ("because it has the money") to the detriment of the medical school.[14] In addition, he wanted to establish a medical center council with representation from faculty members who were not chairmen and students to advise him, the effect of which would be to dilute the traditional ability of the department chairmen to influence the dean's decisions.† This plan reflected what Dr. Arnold Relman‡ called Gellhorn's "wider, more democratic view of medical school administration."[15]

Although the late 1960s and early 1970s was a period of significant student unrest, Gellhorn found this time "invigorating since I was very interested in the issues minorities and students were bringing forward."[14] Gellhorn believed that Penn should assume greater responsibility for the medical welfare of those living in the surrounding community,[16] many of whom were indigent and many of whom were black. "I thought Penn should add a fourth leg to the three-legged stool that medical schools talk about [teaching, research, clinical care], and the fourth leg should be community service."[14]

"Visionary, but on a charger and sometimes out on a limb," as one of the senior members of the Penn faculty described him,[10] Gellhorn was, according to Relman, "liberal in general political complexion, a proud, strong, and independent man who believed in big academic government."[15] Gellhorn's operating philosophy could be summarized in this statement he was heard to make about the duty of deans: "You don't preside over these schools, you change

* Dr. Rhoads died on January 2, 2002, at the age of 94.[13]

† In the early 1970s, department heads at Penn were definitely "chairmen," not "chairs."

‡ Relman was chairman of the department of medicine at Penn from 1968 to 1977 and, afterward, editor-in-chief of the *New England Journal of Medicine*.

them"[17]—a point of view to which his successor at the school of medicine in the 1990s strongly subscribed.

Gellhorn favored a full-time system for the Penn clinicians, not the structure in most of the departments at the time and one that alarmed many for administrative and financial reasons.[15] The chairman of the department of surgery was convinced that putting the doctors on the medical school payroll would bankrupt the university.[17] Nevertheless, Gellhorn, supported by the provost, law school professor Curtis Reitz, forced the school to accept the group practice concept modeled on the plan that Arnold Relman was applying in the department of medicine[17] and that William Kelley would introduce at the University of Michigan when he took over the leadership of the department of internal medicine there in 1975.

Gellhorn also wanted the staff working at the Graduate Hospital, the second hospital that Penn owned, to become more fully integrated into the Penn medical family. Graduate Hospital[18] had been incorporated into the university in 1916 as the clinical teaching facility for the University of Pennsylvania Graduate School of Medicine that provided postgraduate training to physicians and surgeons. With the role of the graduate school decreasing, Gellhorn wanted the hospital to become the center for his primary care and community medicine initiatives.[16] He also favored closing some of the specialty departments there, a proposal that aroused much resistance from well-established doctors at the hospital.[19]

Meanwhile, leading HUP physicians and surgeons favored keeping the Graduate physicians outside the Penn academic orbit and not according them equal status with those working at HUP.[15] They believed, Relman remembered, that these doctors should be left "in the outfield—that's where they belong."[15] An undercurrent to this conflict was the unspoken fact that many of the Graduate staff were Jewish[15,17,20] whereas HUP was still staffed, for the most part, by the traditional Main Line WASP[17*] contingent that had long dominated Penn clinical medicine.† In the late 1960s, a residue of polite anti-Semitism still flourished in certain strata of Philadelphia society and among some at Penn's medical school.

* This well-known acronym has Penn origins. It was popularized by the work of E. Digby Baltzell (1915–1996),[21,22] a longtime member of the faculty in the department of sociology at the University of Pennsylvania.[23,24]

† Martin Meyerson, the president of the university from 1970 to 1981, remembers being "shocked by how many of the medical faculty were in the social register" compared with the faculty in other schools and departments of the university.[20]

Although his origins were Jewish, Gellhorn thinks he was acceptable because he came from a distinguished St. Louis,* not a Philadelphia, family, had been educated at Amherst College and the Washington University School of Medicine in St. Louis, and had been vetted by Columbia University, where he had become professor of medicine at the College of Physicians & Surgeons. These prejudices were slowly changing at Penn, however. Relman, who also had a Jewish background, explains, "I was from Boston, not Philadelphia, and had demonstrated adequate academic accomplishments to qualify."[15] Whatever role anti-Semitism may have played in the events to follow would have been anathema to Gellhorn, Relman says, "a principled and egalitarian man with an instinctive dislike of elitism."[15]†

Spending medical center funds to improve Graduate Hospital did not appeal to the clinical chairs at HUP, who were clamoring for additional money for their own projects. One of their favorites was the Centennial Plan—HUP would soon be 100 years old—a large and expensive rebuilding and expansion of Penn's university hospital. Dr. Edward Stemmler, then a member of the dean's office, believed that Gellhorn saw this and other efforts for adding to HUP as inappropriate to the health needs of the region and the university.[16] As was so often the case with Gellhorn's ideas, they were ahead of the time. Years later, closing, rather than building, new beds and emphasizing primary care would become the mantra for many academic medical centers. However, this was not yet the case in the late 1960s. Although it was the university trustees advised by David Goddard, the provost at the time, and not Gellhorn who killed the Centennial Plan,[17] some of the clinical chairs held Gellhorn responsible for opposing additions to HUP throughout his tenure.

Further adding to the anti-Gellhorn mood, university president Martin Meyerson remembers, many trustees had concluded that "Gellhorn favored

* Gellhorn's father was chairman of the department of obstetrics and gynecology at Washington University and Barnes Hospital. His mother, whose father had been one of St. Louis's leading physicians, helped to found the League of Women's Voters. Gellhorn's sister Martha, once married to Ernest Hemingway, was a notable war correspondent and author. Gellhorn's brother Walter, an internationally recognized legal authority, was a leading member of the Columbia University law faculty.[25] When recruited to Penn, Alfred Gellhorn was director of the Institute for Cancer Research at the Columbia University College of Physicians and Surgeons in New York City. He describes himself and his family as "all Jewish atheists."[14]

† Dr. Jonathan Rhoads differs with the description of the school of medicine and HUP as anti-Semitic. He points out that Dr. Isidor S. Ravdin, Rhoads's predecessor as chairman of surgery and a dominant figure in medicine at the university and nationally for several decades, was of Jewish descent.[12] One of HUP's principal buildings is the I.S. Ravdin Institute.

socialized medicine,"[20] and that he was seen as a "dangerous leftist,"[20] opinions they almost surely learned from disaffected members of the faculty. Despite the recent development of Medicare, "socialized medicine" in those days still constituted the battle cry of doctors throughout the country with a conservative viewpoint. Gellhorn "became the *bête noire* of the conservative Main Liners who ran the place," Relman remembers. "They never understood why he was recruited and didn't like him. The chemistry was never good"[15] between Gellhorn and these physicians, many of whom treated and could, thereby, sway the opinions of university trustees and other citizens influential in Philadelphia business, law, and society.[20]

Programmatically, most of the senior clinical faculty did not think that providing primary care services to the surrounding community, a responsibility Gellhorn wished the school and HUP to assume, "embedded as we were in a depressed area,"[14] was a role Penn should emphasize. "Rather than focusing on doing good in the local community," Jonathan Rhoads, then chairman of surgery, would have preferred that Gellhorn place his emphasis on "advancing the science of medicine and the stature of the school among the academic medical institutions of the country."[12]

Administratively and financially, several chairmen of clinical departments feared the effects of Gellhorn's efforts to centralize medical school authority in the dean's office. Gellhorn remembers how distressed they were by "my temerity to suggest there should be some sharing of the income earned by the clinicians."[14] Gellhorn was referring here to his desire to coordinate and consolidate clinical income in the school, a struggle being waged throughout academic medicine at the time. This conflict so alarmed the chairman of the department of ophthalmology that he moved his department out of HUP, "to protect his hegemony,"[14] as Gellhorn saw it, to the affiliated Presbyterian Hospital, where, with a large gift from a wealthy family, he built his own center in space not as readily available at HUP.

Meanwhile, HUP and Graduate—which Penn would sell a few years later—were losing money as occupancy decreased and changing methods of compensation strained income. Gellhorn, who had had little experience in hospital management, was spending untoward amounts of time negotiating with the insurance carriers.[14] The HUP director, who officially reported to Gellhorn, continued to assign funds and equipment to projects the dominant clinical chairmen requested, leaving the dean watching rather than leading and unable to direct physician income toward other institutional goals he favored.[14] Gell-

horn appointed Edward Stemmler to assume charge over the executive director of HUP as associate dean for the university hospital, an unsatisfactory arrangement since the director continued to deal primarily with the clinical leadership.[16] Gellhorn acknowledged, "I wasn't addressing these issues very effectively."[14]

By the spring of 1971, several of the chairmen of such procedure-performing clinical specialties as anesthesiology, dermatology, ophthalmology, radiology, and surgery had let Meyerson, the recently elected university president, know that they wished some of Gellhorn's initiatives to stop. These well-known doctors operated their own private practice groups, cared for influential and wealthy patients, including trustees, and generated much of the income for HUP. They demanded that Gellhorn relinquish his direction of the hospitals.

At about this time, the vice-president for medical affairs, Dr. Luther Terry, whose support Gellhorn badly needed but did not receive,[15] resigned, and, after a search, Meyerson appointed Dr. Robert Dripps, chairman of the department of anesthesiology and one of the fathers of the specialty in the United States, to the post,[20] his duties to commence in July 1972 after completion of a sabbatical leave.[11] Although the dean still governed the hospitals when Dripps's appointment began, by the summer of 1973, the president had decided to assign the direction of the hospitals to Dripps.[11,20] He asked Gellhorn to remain at Penn as dean of the school of medicine.[14,20]

Distressed by the growing resistance to his philosophy and the loss of leadership over the hospitals, Gellhorn responded to recruiting efforts from New York and departed the university at the end of 1973. "I concluded that they didn't want me as I wanted to be there."[14]* Thomas Langfitt, the director of neurosurgery, remembers talking with a depressed Gellhorn. "He really felt deeply about people in this country who suffered. He couldn't understand how a place like Penn could stand in his way." Many at Penn agreed that Gellhorn's

* Gellhorn returned to New York as the founding dean of what became the Sophie Davis School of Medicine of the City College of New York, "a Center of Excellence with the expectation that it would produce primary care physicians providing care in underserved communities," as Gellhorn described its primary mission.[14] The program also assisted minority students, especially African Americans, to receive medical training.[19] The students were selected in high school and completed their undergraduate and medical school work in six years rather than the usual eight. They took their clinical training at the teaching hospitals of other medical schools, mostly in New York State.[14]

Gellhorn regretted leaving the university. "I loved Penn," he said.[14] Gellhorn particularly appreciated working at what he called, "a full university," where the nonmedical departments were close at hand for collaborative work.[14]

efforts were important, but Langfitt heard the traditionalists say, "*We* just don't do it."[26]

The opposition to Gellhorn's initiatives by the privately practicing specialists, who had determined much of medical school policy since the school was founded, constituted what has been called "their last gasp."[11] The department of medicine established a division of general internal medicine, the first unit at Penn and the first in the country, according to Relman, specifically assigned to the academic study and practice of primary care.[15] Under the leadership of Gellhorn's successor Edward Stemmler as dean (1974–1988), the school gradually and painfully centralized financial and administrative authority over the clinical departments. The mechanism was "Clinical Practices of the University of Pennsylvania" (CPUP),* Penn's faculty practice plan, which Stemmler carried through to completion in 1978, thereby instituting a system of full-time employment for the clinical faculty practicing at HUP.[16] With HUP's financial problems temporarily contained during the 1970s, funds could flow from HUP to the medical school, which Stemmler used for capital improvements and the appointment, during his term as dean, of nineteen department chairs and two institute directors and the creation of a muscle institute and centers for cancer and diabetes.[16] Stemmler convinced the Howard Hughes Medical Institute to choose Penn as one of the American medical schools in which to create funded faculty positions and build much-needed laboratories.[16]

Creation of the Medical Center

As the 1980s progressed, senior university officials and trustees saw HUP, the medical school, and CPUP "each fighting with each other," and felt that a major problem was the "chairs running things."[27] University president Sheldon Hackney, who had succeeded Meyerson in 1981, feared that financial pressures on the hospital would persist indefinitely, that "no one was in charge of it all."[28] Concerned that the hospital leadership pay adequate attention to the needs of the medical school, Hackney concluded that the medical establishment needed "more integrated leadership."[28] At the time, the director of the hospital and the dean reported separately to the vice-president for health affairs for administrative and financial matters with the dean also reporting

* "CPUP," pronounced "SEEpup."

to the provost of the university for academic affairs.* The authority of the vice-president, however, had become limited to general responsibility for the hospital[28] and coordinating, but not directing, the university's health-related schools.[16]

In addition to the vice-president, the director of HUP was also guided by the health affairs committee of the university board of trustees.[29] According to Samuel Ballam, chairman of the committee from 1972 to 1987, the dean, Edward Stemmler, Mark Levitan, HUP's executive director from 1974 to 1982, and his successors, "did all they could to keep the vice-president out of the day-to-day operations of the school of medicine and HUP as much as possible."[30] Levitan remembers that, although the vice-president set his salary, "I looked to Sam and the board for guidance. Tom [Langfitt, the vice-president for health affairs†] stayed out of operations."[31]

Thus, Ballam, a Philadelphia banker and not a health care professional, strongly influenced the operations of HUP although not as much as had some of his predecessors.‡ On Sundays, once or twice a month, the vice-president for health affairs, the executive director of HUP, and its chief financial officer met at Ballam's house on the Main Line[32]§ to sort out the issues and plan the meetings of the board's hospital committee.[9] Ballam, also a university trustee

* In the 1930s, Penn had changed the title of its chief executive from provost to president in accord with the practice at most other universities. The title *provost* was then assigned to the chief academic officer.

† The title had been changed from "Vice President for Medical Affairs" to "Vice President for Health Affairs" when Langfitt took the job in 1973.

‡ Although Ballam, the leader of HUP's trustee committee and now in retirement, resides in an upscale suburb, his origins were more humble. After attending a Philadelphia high school and serving in the Armed Forces during World War II, he obtained a bachelor's degree by attending Penn's night school. Starting near the bottom, he rose to the presidency of the Fidelity Bank, one of Philadelphia's largest. Now he could afford to live in one of the high-cost suburbs and devote time to eleemosynary activities such as HUP. Former health affairs committee chairman Orville Bullett, a member of the Fidelity board who brought Ballam onto the HUP committee and the university board, did represent the established Philadelphia social tradition.[30] Bullett's practice of supervising HUP's operation "on his own and keeping the university out as a benevolent dictator," however, led the president at the time, physicist Gaylord Harnwell, to replace him in the early 1960s, remembers Paul Miller Jr., chairman of the health affairs committee from 1965 to 1969 and later chairman of the university trustees.[29]

§ The Main Line, emblematic of the leafy suburbs where Philadelphia wealth and society are presumed to reside, stretches northwest from the city straddling the tracks of the main line of the former Pennsylvania Railroad from Philadelphia to Pittsburgh. As the railroad was building in the middle of the nineteenth century, the company encouraged its executives to live in the new towns created along the line, thereby promoting the commuter business. Several of the towns were given romantic, Welsh-sounding names such as Bala Cynwyd, Bryn Mawr, Gladwyne, and Radnor.[32]

and a member of several important trustee committees, often attended meetings of the clinical chairmen and the executive committee of the full-time faculty's practice group.[30] When Ballam had a serious heart attack and then a stroke and had to resign the chair in 1987, lawyer Richard Brown, also a university trustee, succeeded him. The membership of the health affairs committee responsible for HUP had, by then, expanded to more than thirty people.[9]

The university retained consultant George Kaludis to advise Hackney and the trustees. Kaludis found Penn's medical enterprise fragmented. "The hospital was being run by a committee run by Sam Ballam, who was calling the shots, and operating on its own," Kaludis observed.[33] "Sam was occupying a management position by default and was operating in a quasi-executive manner."[33] Kaludis saw that the dean had little authority over the hospital or the practices, and concluded that the vice-president for health affairs was functioning "more like a staff than a line officer. The president didn't have anyone to look to for responsibility and authority. No one person understood or was managing the full medical center economy. The most troubling part was the hospital, which was not operating with line accountability."[33]

Kaludis produced a report for the president and trustees that advised creating a University of Pennsylvania medical center led by a single executive who, reporting directly to the university president, would head each of the three entities—HUP, the medical school, and the practice plan. Ballam's committee would, accordingly, be taken out of the direct line of authority. Kaludis also advised that the university create a new trustee committee for the medical center. "The purpose of the new medical center organization," the *Philadelphia Inquirer* quoted Hackney saying, was to "integrate our research and educational operations with patient care. . . . We needed to streamline our decision-making proceedings so we could make timely decisions . . . and develop a strategy, a new environment, for health-care delivery that would be attractive to patients."[34*]

The trustees accepted the consultant's recommendations, and Hackney appointed Stemmler, then the dean, to the new job of executive vice-president for the medical center. "No one but Ed could have done the transition, bringing

* Hackney, who retired from the presidency in 1993 to become chair of the National Endowment for the Humanities in the first Clinton administration, resumed his professorship of history at Penn two years later and currently teaches several courses there. He continues to believe that creating the integrated governance system for the medical center was essential for Penn's progress.[28]

operations together," Hackney remembers. "He was much admired and supported by the senior faculty."[28*] For the first time at Penn, the leadership of the school, CPUP, and its principal teaching hospital would be united in one official.

"I agreed to take the job," said Stemmler, "but only if it excluded responsibility for the other schools [dentistry, nursing, and veterinary medicine]."[16] With the medical center having been established in 1986, a concept that "made real sense to me,"[26] Langfitt saw that the vice-presidency for health affairs had become a "nonjob"[26] since the enterprises of greatest interest to him, HUP and the medical school, no longer reported to him. During his term as vice-president from 1973 to 1987, Langfitt had advised the university to close the school of allied medical professions (SAMP) and sell the Graduate Hospital, actions that did not endear him to the supporters of SAMP or the doctors at Graduate with close ties to Penn.[26] Although he continued to direct the division of neurosurgery and perform operations during his vice-presidency, "since my office was in College Hall," Langfitt remembers, "I became identified with the central university and less with the school of medicine."[26] This perception of the vice-president's role was in keeping with the purpose of the job to run the medical establishment from the center of the university's administration.[17]

Although the vice-presidency no longer attracted him, Langfitt could have continued at Penn as director of neurosurgery. He decided, however, to "start a new career" in the spring of 1987, and became the director of the Glenmede Trust Company, which administers the Pew Charitable Trusts established by the founding family of the Sun Oil Company.[26] Langfitt had served on the board of Glenmede since 1979. The university subsequently abolished the position of vice-president for health affairs.

Resignation of Stemmler

In 1986, Stemmler, now having authority similar to that exercised by Gellhorn fifteen years earlier, recruited Edward Schwartz, then CEO of the University of Minnesota's teaching hospital, as executive director of HUP.[35] When

* Stemmler, who is now retired, graduated from Penn's medical school in 1960 and trained at HUP in internal medicine, cardiology, and pulmonary diseases. He directed the university's medical service at the Philadelphia Veterans Administration Hospital (1967–1973) and then worked as an associate and acting dean before being named dean in 1975.

Schwartz arrived, HUP was breaking even on operations, but just barely.[36] "It was an institution," Schwartz saw, "on balance about to go out of balance because of bills."[36] The hospital's new billing system was failing, and accounts receivable "went through the roof."[36] Until this issue was resolved by reemploying an earlier vendor of information systems, income was severely curtailed.[37] Schwartz was impressed with how much money the hospital was transferring to the clinical departments for support of their faculty and other expenses. Painfully, he renegotiated these arrangements, not winning friends for himself or Stemmler among the chairmen because of the cuts he found necessary to make.[36] Schwartz also reduced other hospital expenses, partly by layoffs.

Meanwhile, the dean and his chairs were fretting over Penn's chronic lack of research space. Each medical school ranked in the top 10 for research had more laboratory space than Penn, and Stemmler knew that research space correlated closely with research productivity and grant support. Some chairs considered leaving unless more research space became available,[38] although Stemmler remembers none raising this possibility with him.[16] Stemmler had led the effort to construct a new building in the late 1970s with research laboratories but also much-needed lecture and conference rooms and student laboratories.*

By the mid-1980s, Stemmler and the chairs were seeking the means to construct a new clinical research building with laboratories for investigators in the clinical departments that were particularly short of space. Leading sources to pay for the building were the Howard Hughes Institute and the Philadelphia-based Pew Charitable Trusts. The clinical departments were also prepared to invest some of their surpluses in the new laboratories. Since at the same time the university was raising money for its arts and science programs, Stemmler's efforts could have produced another conflict between the medical school and university as had troubled Penn when William Pepper was trying to raise money to open HUP more than a century before. In this case, however, Hackney agreed that the medical school should receive most of the Pew money to construct its building, and a potentially divisive conflict was avoided.[28] Consequently, this episode did not further widen Spruce Street.

Meanwhile, in 1988, when the effort to convince a suitable Penn faculty member to take the position of senior executive dean to assist directing the

* This building would be named for Stemmler.[16]

medical school failed, Stemmler told Hackney that he wished to resign as dean, a position he had held in acting or permanent capacity for fourteen years, and let Penn recruit a successor.[16] Although unenthusiastic about having a separate dean and executive vice-president, Hackney told Stemmler, "We'll try it your way."[28] An acting dean was appointed, and a formal search began.

Dr. Claude Bennett, chairman of the department of medicine at the University of Alabama at Birmingham, was among those offered the job.[39,40] He had a very favorable interview with President Hackney, whose Southern roots blended well with those of Bennett,[41] but Bennett did not move. Alabama presented a tempting offer to convince him to stay in Birmingham, and, feeling that Penn still had to resolve questions about its administrative structure to make the job attractive, Bennett decided that this was not the right time for him to leave his current position.[40] Another serious candidate, Dr. William Peck of Washington University in St. Louis, visited twice. He found "Penn at a crossroads. The medical school was ready for new leadership. People had great pride in the place, and the deanship would have been a great job."[42] Peck did not require being both dean and head of the hospital so long as HUP was well managed. However, before Penn was ready to act on his candidacy, Peck accepted the dean's position at his own medical school as he told the Penn people he would if the opportunity came his way.[42] William Kelley was also approached, but he told a senior Penn faculty member who inquired on behalf of the search committee if he were interested, "it isn't worth my time just to be dean."[10]

After several "near misses," as he recalls Penn's efforts to find an acceptable dean, Hackney concluded that candidates who had the qualities Penn needed would not accept the dean's position if it required reporting to an executive vice-president rather than directly to the provost and the president.[28] Accordingly, Hackney decided to return to the structure he had earlier envisioned, with one person holding simultaneously the positions of executive vice-president and dean.[28] Stemmler, who continued to oppose this arrangement, offered to resign as executive vice-president but not without some concern for the future of the medical school and hospital, for he saw the university administration usurping the governance of the medical center.[16] His resignation accepted, Stemmler, after a sabbatical leave, joined the American Association of Medical Colleges (AAMC) in Washington as executive vice-president.

The president, meanwhile, "desperately looking for a strong leader," according to Marna Whittington, Hackney's senior administrator, "even considered

spinning off HUP, but we decided we had to turn it around first."[43] The combined job, Hackney concluded, required someone willing to make the tough decisions necessary to reverse the hospital's losses, someone who was, in Hackney's words, "a good administrator, ambitious, and hard-working,"[28] an apt, although measured, description of the man who would soon fill the position. Finding someone with all the necessary skills would not be easy.

Appointment of Kelley

Dr. Arthur Asbury, the former chair of the department of neurology, whom Stemmler had named acting dean, now temporarily assumed Stemmler's former job as acting executive vice-president as well. The search for the dean was converted into a search for the combined position of executive vice-president of the medical center and dean of the school of medicine.[41] Many members of the committee, which met forty-six times in the course of two years during the two searches for a dean and then for an executive vice-president and dean,[41] felt that Penn required someone from outside the university,[43,44] that the medical center "needed to be shaken up,"[45] "some eggs needed to be broken," and that an internal appointment "would not be as weighty, as successful a recruit."[39]

By the late 1980s, HUP was becoming "threadbare," according to Asbury.[46] "Penn had long been seen as stodgy, better than its legacy," says Dr. Alan Hillman, an internist who studies health care through the university's Leonard Davis Institute.[47] "We were resting on our laurels," remembers Dr. Alfred Fishman, a member of the faculty for more than thirty years. "It was a time of complacency."[48] The medical school's educational programs were seen as doing well, but the research programs were mediocre when compared with those of the leading centers, and the hospital was in trouble. The trustees had become alarmed about the potential effect on the university of continuing red ink from the medical center, although the amount in the late 1980s would pale in comparison with the losses generated ten years later.

At the behest of several members of the clinical faculty, two officers, one from the faculty senate[49] and one from the medical staff,[45] told Hackney that the school needed a dynamic person and that he would almost certainly have to come from the outside. One of them said to the president, "As an historian [Hackney's academic work centered on the history of the American South], you don't want the country's first medical school to go down the tubes."[49]

Much of the power in the school had come to reside in the clinical practices executive committee (CPEC), a group of the leading clinical chairs who met Friday mornings at 7:00. Projects which the dean wanted that these chairs opposed were not carried out.

Many faculty members believed that these leaders should bear at least some responsibility for the continuing losses in the hospital at a time when most academic medical centers were not having such financial difficulties.[50] As Dr. Elliot Sussman, executive director of CPUP from 1987 to 1989, remembers, "HUP had been very successful in the 'cost-plus environment' [when insurers paid the providers most of what they charged] but, when that changed, it suffered as a very high cost place."[50] HUP had been producing surpluses during the 1980s—$16 million in 1986–1987, for example[51]—but that was the last year, and as new methods of compensation started to bite, the hospital began to lose money. Furthermore, in 1985, the new Founders Pavilion, a large addition to HUP, opened, and the hospital had to absorb the interest on the loan and depreciation for the building.[30]

Penn was now "looking for a 'CEO-type' for the job," as a senior member of the faculty and the search committee observed.[44] Members of the committee, however, were "not overwhelmed" by the unexpectedly small number of credible candidates who "bubbled up."[39] One of the most suitable was Claude Bennett, but members of the search committee concluded that the counteroffer from Alabama to keep him during the dean's search precluded Penn's being successful the second time around.

The committee then considered William Kelley, whose candidacy had been strongly supported by such advisers as Dr. Samuel Thier, then the president of the Institute of Medicine of the National Academy of Sciences.* From meeting with Kelley and listening to colleagues who knew him at Michigan and elsewhere, the committee members learned that Kelley was a very intelligent man, had built an excellent department of internal medicine at Michigan, and might be able to do the same for Penn's medical school and hospital. Richard Worley, an investment executive on the university board of trustees who was advising Hackney about the appointment, "feared we couldn't find a person excellent in both [academics and business]." After interviewing Kelley, however, Worley

* Thier, a nephrologist, had been a member of the Penn faculty from 1969 to 1974 and would become the second president of Partners Healthcare System, Inc., the company that owns the Harvard-affiliated Massachusetts General and Brigham and Women's hospitals in Boston.[52]

thought, "here was the guy who might do it."[53] Richard Brown, Samuel Ballam's successor as chair of the hospital's committee and the only nonfaculty member on the search committee, summarized the opinion of many: "We knew he was dynamic and forward looking."[54] Princeton University president Harold Shapiro, who had known Kelley when Shapiro was president of the University of Michigan, told Dr. Nicholas Gonatas, the chairman of the search committee, "Kelley's a sterling man, impeccable in relations with administration."[41]

Kelley's personal reputation, however, was less glowing than his accomplishments. "Tempestuous, made enemies," said some at Michigan, although a chair there added, "he's tough, but he's four-square."* Committee members wondered whether Kelley was really a "Penn person," by which they meant someone collegial and interactive, not confrontational, competitive but not cutthroat. One participant concluded that his character would not change, and that, if he were appointed, the Kelley they were hearing about was the Kelley they would get. However, observed Peter Nowell, a distinguished scientist who had formerly led the department of pathology, "We didn't appreciate how arbitrary and strong he would be."[44] Several of the clinical chairs wrote to the president and provost recommending that Arthur Asbury, the acting executive vice-president and dean and a popular member of the senior faculty, be appointed to the job permanently.[27,55]

Despite reservations about him, however, Kelley became the committee's unanimous choice.[41] They "bought his vision, based on his experiences at Michigan, that he could save the hospital and use hospital surpluses to support academic programs of the entire school," Gonatas recalls.[41] Before taking the final step, Hackney called the members of the committee to his office and questioned them individually about their choice and the search process.[41] Satisfied with what he heard, Hackney offered Kelley the job. Kelley then told the president of the University of Michigan about the Penn offer and said that he was prepared to stay in Ann Arbor if Michigan created a similar position for him there. At Michigan at the time, the dean and the hospital director reported separately to a vice-president for health affairs who in turn reported to the president. Michigan was not prepared to change this arrangement for Kelley's

* Some at Michigan had feared that Kelley might be named to a position there similar to the one Penn now offered. A senior professor in Ann Arbor acknowledges that many of his colleagues were afraid of Kelley-type quality. "As a result, you get mediocrity. Now we do what is easy about appointments," rather than adhering to Kelley's stringent and, to some, annoying criteria.

benefit. Accordingly, Kelley accepted Hackney's offer after negotiating a generous package, "like one in the for-profit world,"[43] and being assured of the independence he needed to do what he saw necessary to raise Penn's standing among the country's leading academic medical centers.* The university announced the appointment on August 2, 1989, five months after Stemmler had resigned.[56]

Kelley proceeded to charm the members of the board of trustees, appearing to them as a business-oriented executive with vision, ideas, and enthusiasm who would change the current Penn style and take Penn medicine to the top.[43] Trustees who thought that Penn was not moving forward liked his approach.[48] Kelley further impressed the trustees by visiting those most involved with the medical center in their offices. During his acceptance speech to the board, he could refer to the trustees whom he had met by their first names. "He won them over," Al Fishman remembers. "A cheerleader and visionary, he was a breath of fresh air. Everybody started to see the stars he envisioned and line up on his side,"[48] but Kelley knew that to maintain the trustees' support, he must produce results quickly. "He articulated a vision that could only be called grandiose," said Donald Langenberg, a university trustee during Kelley's tenure.[57] "It's difficult for a research university already near the top of the research-funding list to change its standing," said Langenberg, a physicist who, as former chancellor of the University System of Maryland and previously of the University of Illinois at Chicago, understands these matters. "Bill made good on that side."[57]

Although, once appointed, Kelley showed his interest in his new responsibilities by visiting every department[58] over which he now had charge, the presence of the new chief alarmed some senior hospital and medical school officials. Edward Schwartz, the hospital CEO appointed by Stemmler, knew Kelley from Michigan where, according to one Penn observer, "they weren't buddies." Kelley had advised Michigan to fire him as chief operating officer, Schwartz remembered.[36] Schwartz told Stemmler that if Kelley came to Penn, "It would only be seconds until I'm out of here"[16]—an accurate prediction. Kelley informed Schwartz that he wanted to bring his own person to Penn to run HUP.[36] In the medical school, the chair of the department of medicine told

* To assist him in negotiating, Kelley brought his lawyer to some of the meetings with Penn officials in which the terms of the position were discussed. As any medical academic knows, the presence of a lawyer at such proceedings is distinctly unusual.

a member of the search committee that if Kelley became dean, "I'm out." He could not imagine working for him, and, a year later, retired from the chair.

Sheldon Hackney, the Penn president who appointed him, remains deeply impressed with Kelley's abilities although he recognizes that "a little more diplomacy would have gotten things done better. In changing fast, he broke a lot of crockery."[28] His executive vice-president, Marna Whittington,* told Hackney, "Kelley will need to be managed." She felt the presence of "warning signals. He's on the edge all the time. The challenge will be to 'gate' his ambition, to pace and budget him," which, she feared, he would be unable to do by himself.[43]

The president, however, was relieved. He would have, in Whittington's words, "a strong, bright person to deal with the docs."[43] Hackney acknowledges that he and the search committee had uncovered few academic doctors up to the job. "Where could you have found someone with his knowledge base and a complete set of leadership skills?"[28]

* Whittington, who worked in the president's office at Penn from 1984 to 1992, later became a senior executive with the financial firm of Morgan Stanley Dean Witter.

CHAPTER THREE

Kelley the Builder

The Philadelphia Medical Market

"One of the most difficult markets in America"[1] was the description often given to the Philadelphia medical scene by the mid-1990s, a time producing severe problems that William Kelley would face as his tenure at the University of Pennsylvania progressed.[2] Throughout the decade, enrollment in HMOs and preferred-provider organizations grew, payments from indemnity insurance decreased, and, although the use of hospital beds declined, Philadelphia's less successful hospitals persisted in staying open, producing a surfeit of unoccupied beds.[3]

Almost unique to such a large area with as many people as in the Delaware Valley, only two carriers, U.S. Healthcare[4] and Independence Blue Cross, provided the health insurance for 80 to 90 percent of the private market as well as the majority of Medicare and Medicaid recipients enrolled in managed care.[1,5,6] Why Philadelphia has so few health insurers intrigues medical economists. "U.S. Healthcare started here, so its dominance is idiosyncratic," according to Mark Pauly of Penn's Wharton School. "The Blues have long had preferred positions in the East and Midwest, thanks to their political positions and special enabling legislation."[5]

Increasingly, one insurer was leading the Philadelphia market. Independence Blue Cross, claims Fred DiBona, its chief executive, held 72 percent of the privately insured market* in the region as the new century began, a position that he sees as a mixed blessing.[8] As DiBona explains, "The biggest chip we have is not bargaining [with a hospital], but the second we won't contract, we put them in a difficult position, and we can't deal with that politically."[8] Blue Cross is then put under great pressure from the state legislature and public interest groups. "The bigger you get," says DiBona, "the larger the responsibility."[8] To some extent, Blue Cross remembers with pleasure, when U.S. Healthcare was larger. "Then," say the Blue Cross executives, "everybody hated them. Now we bear 100 percent of the heat."[7-9]†

Health care costs more in the Philadelphia region than in many other parts of the country. Blue Cross executives attribute this to inordinately high utilization of medical services and "the heavy presence of medical school/teaching institutions."[8,9] They suggest that one reason for this finding is the relatively slow invasion of managed care into the Delaware Valley, which has delayed hospital executives' instituting the administrative and financial discipline required by this method of payment. CEOs from elsewhere taking jobs in Philadelphia hospitals "have been astonished by the inefficiencies and poor management," according to senior officers of the insurer.[7-9] Also contributing to the high utilization, medical practices, to a degree unusual in many cities, continued to operate in a fragmented[7,9,11] manner since Philadelphia has fewer multispecialty groups, which tend to operate more economically than smaller practices.[9] These explanations do little to calm hospital executives in the region, most of whose charges were losing money caring for Blue Cross patients as the twenty-first century began.[10]

As befits the city with the nation's first hospital and first medical school, Philadelphia has become a center of political medicine and medical training. Several professional medical organizations have headquarters in Philadelphia.

* Because of the large amount of traditional Medicare business in the Philadelphia region, however, Independence Blue Cross provides only 30 percent of all hospital revenue.[7]

† Aetna Life and Casualty (now Aetna Inc.) bought U.S. Healthcare, a Philadelphia-based HMO, in 1995 for $9 billion, later said to be three times its value.[4] Retaining 30 percent of premiums for administrative expenses, marketing, salaries, and profits, U.S. Healthcare in the mid-1990s had one of the industry's lowest medical loss ratios (the amount the insurer spent for health care as a fraction of its income from premiums). During the last half of the 1990s, Blue Cross absorbed much of U.S. Healthcare's penetration in the Philadelphia region's market due, in part, to Aetna's loss of its "locally based experts," according to consultant Gerald Katz.[10]

About one-fourth of the country's doctors have worked in the city at some time during their careers, as medical students, trainees, practitioners, or faculty members.[1,12] Only two other states provide more graduate medical education than Pennsylvania.[1] As the 1990s began, Philadelphia was home to six medical schools* and their teaching hospitals, each seeking funds from, essentially, two HMOs.[5,12] The city clearly had, in Pauly's opinion, "too many academic medical centers per capita in a very competitive, hostile environment for care with very unforgiving rates."[5]

Further contributing to the troubles of the older hospitals within the city, the Commonwealth of Pennsylvania, "the only state with no plan for charity care," according to a local health care consultant,[10] persisted in paying its hospitals and doctors "paltry amounts"[10] for the care of its economically deprived citizens.[5] With a Republican governor, two Republican senators, and the legislature controlled by Republicans in 2001,[1] the chief executive of the regional hospital association was not alone in describing Pennsylvania as "not progressive or out in front on health care issues."[1] Even so, health care constituted the only substantial industry in the city of Philadelphia in which employment and business grew during the 1990s, thereby making Philadelphia "more dependent on health care than any comparable area in the country."[1]

By the end of the decade, most local residents on Medicaid would be supported by managed care contracts with their ability to constrict payments for needed services.[6] Formerly, the Philadelphia General Hospital (PGH) cared for many of these patients, but the city had closed the public PGH in 1976.[13] Built in the early nineteenth century on property adjacent to what would become Penn's medical complex, many of the former PGH patients from the surrounding low-income areas of the city now came to HUP, gradually worsening its payer mix,† decreasing the fraction of its charges the hospital could collect, and further politicizing the financing of its health care. As Pauly observed, "The city no longer offered a safety net for poor patients."[5]

Philadelphia lacked dominant private employers[14] who might be prepared to accept more expensive arrangements with hospitals and doctors. Such employers in other cities supported local institutions and responded more posi-

*In addition to Penn, Philadelphia's medical schools included Hahnemann, Jefferson, Medical College of Pennsylvania (MCP, the former Women's Medical College), and Temple, plus the Philadelphia College of Osteopathic Medicine. Hahnemann and MCP would soon merge.

† "Payer mix" is hospital administrator-speak for the distribution of a hospital's revenue by source, usually an insurer.

tively to what their employees might want.[5] Philadelphia had become increasingly a "branch town,"[1] with fewer leading executives tied to the region by family or business traditions and willing to take on the insurers and their powerful lobby for the sake of the hospitals. Furthermore, health care partisans claimed, executives and members of company boards also sat on the insurers' boards, decreasing the likelihood that Philadelphia business leaders would advance the hospitals' concerns. "We don't have a set of employers who could run around the insurers and deal directly with providers as in Minneapolis," says Mark Pauly.[5]

Salvaging the Hospital of the University of Pennsylvania

As Kelley began working at Penn at 7:00 A.M. on October 1, 1989, reversing the losses and improving the infrastructure at HUP constituted one of his first jobs. In this, he and his colleagues succeeded so well that for several years the hospital operated as a "money machine."[15] Kelley critics, at the time, contended that the turnaround had begun under Schwartz and Stemmler, and that the new team was not adverse to taking full credit for the new green ink. Schwartz confirms that "by the time Bill arrived, we were beginning to pull out but weren't quite there yet."[16] The hospital, as Schwartz remembers, was losing $6 to $8 million when he left.

A month after Kelley arrived, "Bud swoops in," as one close observer said. Bud was Wilbur B. Pittinger, Kelley's new director of HUP and his former chief administrator in the department of internal medicine at Michigan. Intelligent and capable, Pittinger was seen as Kelley's alter ego, a role he also played at Michigan.[17] "Bill's a big picture guy, not a nuts and bolts type of person," says Dr. Tadataka ("Tachi") Yamada, Kelley's chief of gastroenterology at Michigan and subsequent successor as chairman of the department of medicine there. "Most of operations were left to Bud, and that's where he was necessary to Bill."[17]

Knowing that he wanted to take Pittinger with him, Kelley asked him what job he wanted at Penn. Pittinger picked executive director of HUP.[18] Switching from administering a department of medicine at a Midwestern state medical school to directing the leading academic hospital, owned by an Ivy League private university, in the large eastern city of Philadelphia, with 727 beds, 5000 employees, and a $550 million annual budget was, in Pittinger's words, "quite a stretch."[18] The new executive director inherited a hospital that was losing

money, was borrowing from the university to make the payroll, and "didn't have a nickel for capital improvements."[18]

With the support of Kelley and the trustees, Pittinger replaced more than half of the senior hospital staff; he also recruited new, competent administrative officers and paid them well. John Wynne, the newly appointed chief financial officer, converted half of the $100 million in accounts receivable to cash and installed contemporary expense controls. When the new team arrived, HUP had $5 million in cash, by 1994, $528 million.[18] "There was so much fat that it was easy to cut," remembers Dr. Alan Hillman from the Leonard Davis Institute of the Wharton School.[19]* Personnel were let go and unproductive programs were closed,[19] in both the hospital and the medical school. The changes fulfilled two of Pittinger's mottoes: "One has to pay attention to money," and "financial problems are usually the result of other problems."[18]

As chief operating officer of HUP, Pittinger, along with Kelley, hired Jeffrey Otten, a professional hospital administrator from the medical center of the University of California, Los Angeles. Otten was attracted to the job because of the unified governance at Penn, "where incentives were more closely aligned among the school of medicine, hospital and practice plan." At UCLA at the time, the CEO of the hospital and the dean of the medical school often fought with each other.[20] "Neither Bill nor Bud had run a hospital," says Otten. "They needed someone with experience."[20] The federal, state, and city governments had cited HUP for 125 violations of life safety codes[20] and were threatening to close the hospital.[21] Fixing each of the violations would cost an estimated $80 million.[20]† The new hospital leaders found no master plan and, as Otten thought, "an incredible lack of respect for managing well."[20]

Kelley and Pittinger were very close; they had worked together "for sixteen great years," as Pittinger said.[18] Although they came to work in separate cars, they talked to each other continuously over cell phones, in a personal code, it was said. When one of them made a comment at a meeting, the other would often finish the sentence,[15,22] somewhat disconcerting to those unaware of their close relationship. Since Kelley's ambition was to take "top place in the research hit parade and win a Nobel Prize," Pittinger's job was "to generate the dollars to feed Bill's academic dreams." He fulfilled this assignment magnificently for as long as he was at Penn.

* Pittinger responds, "Alan does not understand how difficult it is to wisely and effectively reduce operating expenses. He should try it sometime."[18]

† The hospital executives convinced the governmental agencies to review their plans and give them some time, and by 1996, all the citations had been removed.[21]

To compete with U.S. Healthcare, the other major medical insurer in the region,[23] Blue Cross offered HUP a highly lucrative contract if the hospital agreed not to contract with another insurer for less.[24] The deal also helped Blue Cross convince the other teaching hospitals in town "to fall into line," as Pittinger remembers the effects of the Penn contract.[18] The contract helped HUP generate annual operating margins of as much as 17.6 percent,[25] surpluses on operations ranging from $70 million to $97 million per year, and annual bottom bottom lines of as much as $122 million. HUP's operating margins during its sunny years were: 1994—17.6 percent, 1995—13.3 percent, 1996—7.7 percent, 1997—6.4 percent.[25] The results looked so good that someone who should know said, "We were looking for places to hide some of the profits."

Some of this money was invested in HUP itself. Much of the hospital appeared to Kelley quite run-down when he took over in 1989.* The recently constructed Founders Pavilion was up-to-date, but many of the other facilities seemed almost like those of a public hospital.[27] Two of the buildings housing inpatients had been condemned.[21] During the decade that followed, Kelley's administration built the Jonathan Rhoads Pavilion† into which many of the beds were transferred from outdated facilities elsewhere which, for the most part, were converted into offices and laboratories. A new veneer was put on the front of the hospital, providing a more convenient and attractive entrance for patients and visitors. Interior changes improved the general ambience, "put tone in the place," as a former chair observed.[27]

Nevertheless, Kelley was criticized for the furnishings he lavished on some of the new buildings at Penn and at the Radnor suburban clinical site. "He built marble-clad buildings rather than cath labs," complained one of the senior physicians. Kelley watchers suggested that more than coincidence accounted for the Biomedical Research Building (BRB) II/III having two more stories than the adjacent research tower that the Children's Hospital of Philadelphia had built.[28]

Kelley dreamed of replacing HUP with a new hospital built across 34th Street from HUP on property on which then stood the city's convention center, soon to be replaced with a new complex downtown.[21] His fantasy structure would include a new university hospital, a behemoth with two million square

* Kathleen Hall Jamieson, dean of Penn's Annenberg School of Communications, observed that finding one's way around the medical complex in the early 1990s when she and Kelley first arrived at the university was like attempting to traverse "the tunnels of the Vatican."[26]

† The Rhoads pavilion was named for the longtime chairman of the department of surgery and onetime university provost.

feet of space,[20] and much-needed outpatient facilities and doctors' offices. Estimates for building and equipping the enterprise exceeded $1 billion.[29]

Fortunately for Penn, as it developed, the city set a price for the property that the university saw as significantly above its fair market value. John Street, then the president of the City Council and later the mayor, backed by the local community, may have been resurrecting the "West Philadelphia versus Penn conflict," a chronic and recurring problem for the university. "We'll stick it to the university," some at Penn thought partially motivated the community and the politicians in their discussions with the Penn officials.[29] After prolonged and sometimes uncomfortable negotiations, the university and health system backed away from purchasing the site. So much the better, thought Gordon Williams, one of Kelley's senior executives. "We would have gone under even sooner if we had built the new hospital and clinics."[29]

With a new HUP no longer an option, priorities of greater importance to Kelley delayed projects important to the functioning of the hospital. As the money ran out by the end of the decade, certain further improvements in the hospital, such as replacing the cardiology laboratories, now fifteen years old, and radiation oncology facilities, would have to be postponed. "Bill had decided to invest in academics over hospital," said Robert Martin, the health system's chief operating officer. "None of us counted on the financial rug being pulled out so soon so that the clinical stuff couldn't be done."[30] With the health system's attention directed elsewhere, it seemed to the executives at HUP that "21 Penn Tower [where Kelley and the corporate team worked] is farther away than just across the street."[31*]

Filling the beds was vital for HUP to prosper. In the 1980s, the census fell so low that at times only 500 of the 700 beds had patients in them.[6] Under Kelley and Pittinger, the clinical departments were pressed to recruit more patients to the hospital. The department of medicine under its new chair, Dr. Edward Holmes, and his colleagues responded so effectively that, in a few years, all the operating beds would be consistently occupied. Since it costs relatively little to fill additional beds—fixed costs in hospitals constitute a major fraction of operating expenses—most of the added earnings became new income.[6]

These improvements assured HUP's preeminence as the leading academic teaching hospital associated with the leading medical school in the region. *U.S.*

* Penn Towers, the twenty-one-storied hotel across 34th Street from HUP, which houses the senior administrative offices, came to be called the "Tower of Power."

News & World Report continued to recognize this by ranking HUP as number 13 in its "Honor Roll" of America's best hospitals for the year 2002.[32]

Kelley's Strategic Plan

"To provide leverage with the managed care plans, we have to be very big,"[33] best describes Kelley's plan,[34] developed in the early 1990s and described as "gigantic" by a close observer.[35] Its principal features included:[24]

- Building a primary care network of general physicians so large that any employee of any employer could get to a Penn-related doctor in fifteen minutes
- Developing a system to deal with fully capitated contracts, including physicians, HUP, and home-health care
- Owning only one hospital, HUP

"Vertical integration" was the mantra. The University of Pennsylvania Health System, officially created in 1993 with approval from the trustees and with Kelley as its first CEO, would be the vehicle.* In addition to HUP and the clinical faculty, the health system would include a large cadre of primary care physicians, nurse practitioners, links with the best specialists and subspecialists in the community, and connections with institutions offering all levels of care, including ambulatory care facilities and nursing homes.[21] In addition, Kelley visualized "horizontal integration" for his venture, although many of these relationships were "virtual" ones involving joint management rather than ownership.[21] "I'm not a believer that horizontal mergers are a great way to go," he said in December 1999, referring to the unions of teaching hospitals that had developed in several cities.[36]† Despite this reservation, however, he would later buy three community hospitals in Philadelphia and its suburbs.

* Kelley refers to the hospitals and external practices as "the clinical component of the health system" and the academic component as "the school component of the health system."[21] After wrestling with these definitions, I have decided to use a slightly different scheme that I find less cumbersome. In what follows, I will use "health system" (without capital letters) for the hospitals and external practices and "school of medicine" and "CPUP," the faculty's practice plan, for those entities. "Health System," in capitals, will refer to the formal structure of the University of Pennsylvania Health System, including the school of medicine, CPUP, and HUP (the three entities that constitute the "University of Pennsylvania Medical Center" at the university campus in West Philadelphia) and the other hospitals, practices, and external clinical relationships that Penn owns or is affiliated with.

† Kelley had looked at the position of CEO of the newly formed Partners HealthCare System, the organization resulting from the merger of the Massachusetts General and Brigham and Women's hospitals, both primary teaching hospitals for the Harvard Medical School in Boston.[36] When asked

Controlling the source of patients constitutes a fundamental concept of the vertically integrated delivery system. This required establishing relationships with the primary care doctors in the Philadelphia region who might refer patients to HUP. Convinced by his consultants, as some of his critics thought, or based on research and planning, as he saw it,[21] Kelley and his team decided that the most effective method of securing this aim was to purchase many primary care practices. "To be the best, we had to be big enough to be the best," was seen as the Kelley motto.

A leading purpose of all this expansion was to achieve a size sufficient to contract more successfully with HMOs. Kelley, however, would continue to assert that the projected size of the health system was based "almost entirely on the needs of the education and training programs at the medical school, specialty and subspecialty levels."[21] Kelley feared that Penn might lose each of its teaching affiliations, other than HUP, and not have enough sites at which to train its medical students.

The extraordinary recruiting and spending activities of the later bankrupt Allegheny Health, Research and Education Foundation (AHERF) would soon affect how Penn developed its health system. AHERF was a not-for-profit integrated delivery system originating in the Allegheny Hospital in Pittsburgh, which expanded rapidly during the 1990s purchasing and then combining the Philadelphia medical schools of Hahnemann University and the Medical College of Pennsylvania (MCP). The corporation also absorbed fourteen hospitals, including those owned by the two medical schools and more than 500 doctors' practices in Philadelphia and Pittsburgh.[37*]

Allegheny and other local institutions were considering the acquisition of Presbyterian and Pennsylvania hospitals, longtime university training sites. Management of patients in the beds in the Philadelphia Veterans Administration (VA) Hospital that Penn had long shared with MCP, might be lost to Penn if Allegheny, which now owned MCP, assumed control of all the professional services at the VA Hospital, as it was trying to do.[21] Finally, the CEO of the

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about that merger, he said, "I thought it was a waste. I never saw consolidations in the market as useful. At Penn, we were trying to do something different."[21]

* Extravagantly overspending its resources, AHERF would file for bankruptcy in July 1998, jeopardizing the future of the united medical school. To save jobs and influenced by the mayoral elections,[3] the city and state rescued the medical school, which the for-profit corporation that bought the AHERF hospitals did not want to own, and asked Drexel University, a Philadelphia engineering school adjacent to the Penn campus, to administer. A substantial contribution to its endowment helped to convince Drexel to take on the responsibility. See the study of the Allegheny debacle by Professor Robert Burns and colleagues from Penn's Wharton School.[37]

Children's Hospital of Philadelphia, where Penn trained its students in pediatrics, was discussing an affiliation with the Johns Hopkins School of Medicine in Baltimore.[21]*

Despite the inherent complications in such a strategy, most of the large and many of the smaller hospitals in the region approached Penn about buying or merging with them.[21,38] Health system executive board member Richard Worley had cautioned in the early 1990s that "buying more capacity where there's too much capacity [too many beds in the city] doesn't make sense,"[39] and although the pressures on him to merge were growing, Kelley adhered, at least for a time, to his policy of not buying hospitals.[40,41]

Kelley acknowledges that the principal force that drove many of his decisions was Allegheny and its CEO Sherif Abdelhak. "AHERF brought bad dynamics to our market. Abdelhak was trying to grab all our best hospitals which forced us to do deals that were uncomfortable though legal and spending a lot of money."[21] Penn's response included buying practices at inflated amounts and, to secure their continued loyalty, paying Penn physicians more than would have been necessary before AHERF started offering large salaries. Then when Penn found itself forced to propose more money to stabilize a busy clinician, other faculty members wanted to know why they were being left out and demanded higher compensation.[41] Thus, Penn's entering the market contributed to its inflation.[29]

Penn's efforts to meet these challenges would take many turns during the decade. "Our view of the future," according to Will Ferniany, senior vice-president for administrative and network services, "came out of the Clinton health care proposal. Everyone predicted, and we believed, that there would be two or three big health care systems partnering with insurers, such as Penn with Aetna and Jefferson with Blue Cross. By 1997, however, this hadn't happened."[24]

Presbyterian Hospital

About a fifteen-minute walk northwest of the center of the Penn campus stands the Presbyterian Hospital, founded by charitable Philadelphia Presbyterians on March 25, 1871, and officially opened a year later, the same year as the better-known Presbyterian Hospital in New York City.[36] For decades, the Presbyterian Hospital in Philadelphia, an independent community hospital with

* Nothing, however, was to come of this extraordinary possibility.[21]

its own board of directors, had enjoyed an affiliation with the University of Pennsylvania Medical School similar to that of Pennsylvania Hospital. By the 1990s, however, the association had deteriorated, with Penn no longer sending students to train at Presbyterian. Most of the house staff programs could no longer compete for American graduates, the only interns and residents obtainable having trained at foreign medical schools.[42] Penn also saw many of the staff members as unsuitable to teach its students.

Pockets of strength, however, remained at Presbyterian. Dr. Bernard Segal, one of the region's best-known cardiologists, had brought his practice and colleagues there and provided a contemporary, busy cardiology service. Penn's ophthalmology department had been based at Presbyterian since the 1970s, when the powerful chair at the time, Dr. Harold Scheie, concluding that HUP was unprepared to adequately support his dreams for the specialty at Penn and, opposed to the dean's efforts, at the time, to centralize authority and financial control, built his Scheie Eye Institute on the Presbyterian campus. Ophthalmology's endowment at Presbyterian approached $80 million. Rebuilding the department at HUP would have been impossible at the time, Kelley concluded.[21]

Although Presbyterian was not losing money,[43] many of its beds were unoccupied, and the financial stresses affecting all hospitals were threatening its survival. The possible closure of the only community hospital in the university's environment, it was said, alarmed Judith Rodin, recently elected as Penn's president. She was thought to fear that if Presbyterian closed, Penn, with its longtime affiliation with Presbyterian, would be blamed for turning its back on the West Philadelphia community, not a particularly prosperous section of the city, whose development she was determined to assist.[42,44] Although Rodin appreciates being credited with this vision, she denies that the purchase of Presbyterian was her idea. "It made me nervous for Penn to own it," she says. "The more we owned [in West Philadelphia] the more the community feared us."[45] She favored creating partnerships to develop the community surrounding the university.[45]

Presbyterian had tried "to find a safe haven in turbulent troubled waters," as an article in the *Inquirer* stated,[46] by merging, a year earlier, with Independence Blue Cross. Although unsuccessful, such an arrangement had alarmed Kelley.[24,47] He was also concerned that Allegheny might purchase Presbyterian, giving a competing academic medical center a presence in Penn's backyard.[19,42]

So, on April 21, 1995, Penn and Presbyterian announced their intention to

merge,[46] in what was, in effect, a Penn purchase of Presbyterian Hospital. For this privilege, Penn paid $88 million into the charitable foundation that operated the hospital, a payment estimated to be about "60 cents on the dollar value of the asset," according to Kelley.[21,48] The purchase also assured that Penn would retain control of the Scheie Eye Institute's endowment.[21]

On the following June 30, Presbyterian ceased to exist as an independent entity and became the Presbyterian Medical Center of the University of Pennsylvania Health System. The university created a new board of trustees for Presbyterian, which included several trustees from the foundation that had previously operated the hospital. Penn became the sole member of the Presbyterian board, a legal arrangement duplicated at the other hospitals the university would acquire.[49] This gave the university full control over the operation of Presbyterian and the right to appoint all members of its board.

Many of the Presbyterian staff saw Penn's takeover in the starkest of terms. "Presbyterian would become a 'CPUP hospital,'" they feared.[42] This meant that those physicians whom Kelley wanted to retain would have to join the practice plan with its corporate, salaried structure and that they would be required to report to the department chairs and division heads at HUP. "Whether Bill was really going to be that rigid," Dr. Jack Ende, a general internist who would become chief of medicine at Presbyterian, speculated, "the doctors saw it as such. The implication left was 'conform or leave'."[42] Kelley agrees that "the transition could have been handled better."[21]

"Penn went in like gangbusters, arrogant, and ended up emptying out the place," in the words of a senior HUP physician who had had experience working at other city hospitals.[14] "The medical staff went ballistic," Michelle Volpe, the executive director at Presbyterian, remembers.[43] As the census fell, the hospital started to lose money so much so that "people thought the hospital would tank."[42] At a staff meeting held at Presbyterian and attended by several of the leaders from Penn, "there was a lot of shouting among the doctors and grandstanding," Ende remembers. Presbyterian loyalists tried to excuse the lack of American house officers as "great for diversity and internationalism."[42]

Many of the most successful doctors looked for a way out. Segal took himself, his group, and his patients to Allegheny. If he had stayed, this senior physician, known for his independence,[44] would have had to report directly to the young molecular biologist, Dr. Judith Swain, the chief of cardiology at HUP. Dr. Edward Holmes, the medicine chair at Penn, and Swain, who is

Holmes's wife, insisted that the cardiologists working in the cardiac catheterization and clinical electrophysiology laboratories be full-time members of CPUP, an intensity of management by Penn that was anathema to Segal.

Penn might have known better. Segal had moved from Hahnemann Medical School and Hospital, where he was chief of cardiology, to Presbyterian in July 1986 to escape an attempt by the Hahnemann president to bring cardiology, which then operated relatively independently, closer into the organization of the medical school.[50] At Presbyterian, Segal directed a team of 100 people, including twenty-four cardiologists and cardiac surgeons in the Philadelphia Heart Institute, housed in its own three-storied building on the Presbyterian campus. "We had the best of all worlds, my ideal setup," Segal remembers. "We had unity, esprit de corps, and the support of the hospital, the community, and our patients. Organizationally, it didn't feel like a medical school environment. We had clinical appointments at Penn but were free of officers and committees."[50] Segal's group had its own fellowship program and produced postgraduate courses for training physicians in cardiology. Each year the group set aside about $700,000 that, along with the philanthropic support developed by its governors and women's board, built the institute and supported its clinical research and health services. The Philadelphia Heart Institute, however, was, essentially, a private practice, not the type of organization that the clinical departments of the University of Pennsylvania school of medicine had become.

After Penn's purchase of Presbyterian, Segal and Kelley met "for fifteen minutes," according to Segal. "They subsequently offered me a staggering four-year contract worth millions of dollars to stay. They were going to give me a chair—what did I need with that—but I would report to Judy Swain."[50] As for his colleagues, Segal was told that those who did not want to become full-time CPUP faculty would be given one-year contracts and then severance when they left.[50]

"Kelley didn't think we'd leave,"[50] Segal believes, but they did. Hearing memories of his experiences at Hahnemann a decade ago, Segal looked around and decided to go with Allegheny, which, not incidentally, now owned Hahnemann Hospital. Before he left, Kelley tried to capture the Philadelphia Heart Institute's endowment of $8 million, deposited within Presbyterian. After difficult negotiations, a court-approved settlement[51] awarded the university $3.4 million, and the rest remained with Segal.[50] Having, with his colleagues and

supporters, developed the entire endowment, Segal remembers this episode with some anger.[50]

On January 1, 1996, Segal and his group left Presbyterian for Allegheny, which built him the facilities he needed.[50] Soon, however, Segal discovered that AHERF would not survive, unlike him and his colleagues. When Allegheny went bankrupt, Jefferson welcomed him, and, in November 1998, Segal and his team moved again. Segal was made chief of cardiology, and the group proceeded to flourish as before. He now leads the Jefferson Heart Institute, built on the model he developed at Presbyterian so successfully. It collects more than $11 million annually and makes surpluses of about $3 million, which he retains for development, pays his colleagues in bonuses, and shares with the medical school and the department of medicine. Segal still sees twenty patients per day, five days per week. He makes some allowance for his 74 years, with his associates covering his practice at night, on weekends, and during the weeks he spends in Florida each winter.[50]

As Segal and other physicians and surgeons with large practices left, Kelley turned to his clinical department chairs to rescue the failing hospital. "You now have the responsibility for Presbyterian. Repopulate it [with doctors]. HUP is crowded. Here you have space. Fill in the gaps."[42] Among the most valuable groups brought in, specifically to replace the Segal operation, were thirteen cardiologists from the Cooper Hospital in Camden, New Jersey, across the Delaware River from Philadelphia.[52] Harvey Waxman, the leader of the group who had worked at HUP before moving to Cooper in 1984, had been having differences with the Cooper management and was looking around. Despite believing that "Presbyterian, in typical university hospital fashion, was ignorant of the real world,"[47] Waxman accepted the offer and arrived in West Philadelphia in September 1997. By the summer of 2000, his group and their associated cardiac surgeons were said to account for 40 percent of Presbyterian's income.* Looking back on the Kelley–Holmes imbroglio with Segal, Waxman muses, "Control was more important than success. That's why Bernie left."[47]

Responding to the opposition of making Presbyterian a CPUP hospital, the leaders proceeded less dogmatically and encouraged community physicians to retain or acquire staff privileges and admit their patients to Presbyterian with-

* As a leading physician at Pennsylvania Hospital noted about Waxman, "He goes, and it closes!"[53]

out having to join CPUP or the Penn faculty or to teach. Most specialists at Presbyterian, however, remained full-time Penn doctors and members of CPUP.[42]

All these changes, however, came at a price. Recruiting replacements for the fleeing former Presbyterian doctors cost the health system significant money just as income was beginning to fall thanks to the efforts of the HMOs and the oncoming effects of the Balanced Budget Act. Acquiring the hospital, which soon began to lose money, and replacing the staff, the magnitude of which far exceeded what the Penn leaders anticipated, reduced the health system's capital and would contribute to the bleak financial results during 1998 and 1999.

Pennsylvania Hospital

Between 8th, 9th, Spruce, and Pine streets in downtown Philadelphia stands the Pennsylvania Hospital, the nation's first hospital.[54,55] Its center section, a handsome classical red-brick building facing a lawn and driveway on Pine Street, includes the original surgical amphitheater on the top floor, which is lit by daylight as it was during the hospital's early years. Since its founding in 1751, the Pennsylvania Hospital ("Pennsy" to its friends) had operated as an independent entity, its board of managers including leading Philadelphians in business, law, academics, and society.

When the University of Pennsylvania was downtown, many physicians at Pennsy held appointments in the medical school and taught students in their hospital. With the relocation of the university to West Philadelphia and the construction of the Hospital of the University of Pennsylvania in the 1870s, the connections between the medical school and the Pennsylvania Hospital decreased, although students still studied there and some Pennsylvania Hospital physicians and surgeons held university appointments.

In 1991, H. Robert Cathcart, the senior executive at Pennsylvania Hospital for forty years, retired.[56] Surviving difficulties in the first years of his tenure—which, he was heard to say, were "not as bad as when the British ran it during the revolution,"[57] Cathcart built Pennsylvania Hospital on what was called the "star system" into an efficient, successful hospital known to be patient- and doctor-friendly. He strongly supported leading surgeons in neurosurgery, orthopedics, otolaryngology (ENT), and urology to such an extent that five of these doctors accounted directly or indirectly for half of the admissions. One of the orthopedists inserted more knee prostheses than any other surgeon in the

country—his record was twenty-six in one day. Another was number 2 nationally in the hip replacement field. The chief of neurosurgery had the largest practice in the Delaware Valley, and members of the obstetrics service delivered more babies than did the doctors in any other hospital in the region. When Cathcart retired, however, many of the leading admitters were in their 50s or early 60s and the rumblings of managed care were reaching Philadelphia.[57]

Cathcart's successor as president and CEO, who had had a troubled relationship with Kelley, was found wanting by several of the leading Pennsy doctors. Part of their discomfort reflected the changes that the economic environment was forcing on doctors, hospitals, and the practice of medicine. Consequently, as the CEO did what he had to do to reduce costs, the doctors saw the savings changing the way they practiced and reducing their income. The hospital president, they concluded, was micromanaging and not communicating and, sin of all sins, conveying the impression that he did not like doctors.[57] Reflecting the power these doctors then exercised, they convinced the board of managers to relieve the president in November 1995.[58] Dr. John Ball, a physician in the executive office who had spent much of his career in administrative medicine, was appointed president and CEO of the hospital just in time to deal with one of the most important decisions the almost 250-year-old hospital would face.

The issue was academic affiliation. Kelley had decided that when Penn provided graduate medical education to hospitals like Pennsy, service affiliations must follow. Otherwise, Kelley was heard to say, why should Penn give independent hospitals like Pennsylvania the competitive advantage of supplying them with house officers and fellows?[53] When an agreement about clinical cooperation between Pennsy and Penn did not follow, the chair of neurosurgery at HUP, with Kelley's approval, reassigned his residents who had been rotating through the service at Pennsylvania Hospital. The Pennsy chief took his need for house staff to Jefferson Medical College, two blocks away. The Jefferson leaders extended a welcoming hand, saying, "you're valued,"[57] and "we're *kind,* not *Kelley.*"[53] Soon, most of the clinical departments at Pennsy had disaffiliated their training programs with the University of Pennsylvania with which the Pennsylvania Hospital had been associated since the middle of the eighteenth century. Throughout these events, many at Pennsy came to see the university as increasingly arrogant.[57]

Jefferson, with one of the largest classes of medical students in the country, depended on widely separated community hospitals to train them. Teaching

on the patients at nearby Pennsylvania Hospital provided a valuable resource. The hospital, however, needed a formal association with one school or the other. Each had its virtues and shortcomings. Jefferson was nearby, and several of the leading doctors and board members had close professional and personal ties with the staff and trustees. Penn had the academics and the long historical connection. Whatever Pennsylvania Hospital did, it must maintain its independence, most participants believed, or as one leader put it, "a merger is a nonstarter."[57] By the time the trustees were scheduled to decide, an informal survey showed the doctors "tilting to Jefferson."[57] On October 28, 1996, the twenty-two-member board of managers voted but could not reach a majority for affiliating with either school.[59] The lawyers and academics on the board tended to favor Penn; the bankers and businesspeople preferred Jefferson.

The adherents of each of the solutions lobbied the managers. Jefferson's supporters emphasized the danger, if Pennsy went with Penn, that several of the big admitters would take all their patients to the Jefferson Hospital, where some held concurrent senior academic and administrative appointments, whereas fewer would flee to Penn if the affiliation went to Jefferson. They also suggested that Pennsy could more readily influence what Jefferson might do while Penn under Kelley was very structured and less predictable. In support of this thesis, Penn had drafted the Penn–Pennsy affiliation proposal, whereas Pennsy wrote the agreement with Jefferson, where everything seemed "very loose, no need to put something on paper."[57]

Penn supporters emphasized that Penn under Kelley was better positioned to dominate the health care market. Jefferson, Pennsy's neighbor, competed more directly for patients living in similar neighborhoods, whereas Pennsylvania Hospital's patients tended to live or work in locations different from many who attended HUP, two and a half miles away. Consequently, might not Jefferson decrease the size of, or even close, Pennsylvania Hospital if the affiliation took that course, a possibility that the Jefferson people "resolutely refused to discuss"?[57]

The executive committee asked CEO John Ball for his opinion, and he told them that he thought associating with Penn was the wiser choice.[57] On November 12, 1996, two weeks after the stalemated session, the board of managers of the Pennsylvania Hospital voted with a majority of one to affiliate with the University of Pennsylvania,[60] a decision that required four ballots. One of the Jefferson-supporting managers had changed his mind, saying, "I can't take it

anymore."[57] Jefferson immediately announced the acquisition of the practices of three of the stars[60] who had previously been appointed chairs of their specialties at Jefferson—ENT, neurosurgery, and orthopedics.[53] Later, one of the other large orthopedics groups decamped, temporarily as it turned out, to Graduate Hospital, part of the Pittsburgh-based AHERF.[61] The word around Jefferson was, "if we can't have the place, we'll shut it down."[53]

A month later, the board decided to convert what John Ball, who is a lawyer as well as a doctor, refers to as a "merger de facto [for all intents and purposes] into a merger de jure [by law]" with the Pennsylvania Hospital, now becoming part of the University of Pennsylvania Health System. Under this structure, Pennsy would retain its name, its identity, and its own board, but the Pennsy managers would become subordinate to the university trustees.[60] The hospital would be managed under contract with Penn to allow consolidation of services.[60] So much for the proud talk of the Pennsylvania Hospital's remaining independent.[62]

Many at Penn were amazed that Pennsy decided to merge with the university rather than affiliate or merge with Jefferson.[14] Granted that the financial realities of the day had dictated Pennsy's association with a larger medical entity, but why did Penn, which had pledged not to buy hospitals when its strategic plan was developed only three years previously, change its mind? Officers in Kelley's administration, some of his trustees, and observers outside the Penn system[1,10] believed that Penn did not need Pennsy, that, strategically, the merger did not add value for Penn, and that this was "absolutely the wrong time to have bought it."[63] Health care consultant Gerald Katz thought the decision unwise. "They bought a highly indebted business which was losing money."[10] Katz, along with many others, saw Penn "acting like lemmings and following Allegheny into the sea."[10] Other critics of the purchase saw it as an ego trip for Kelley to own America's first hospital and beat Jefferson.[64,65] "Let's get big now and we'll figure it out later," several of the health system executives and medical school faculty concluded was the explanation.[14]

Kelley, however, feared Jefferson and AHERF "owning Center City" and Penn having no presence there if Pennsylvania Hospital became part of the Jefferson system.[24] Although a relative newcomer to the University of Pennsylvania, Kelley appreciated the historical connection to Pennsy[19] and needed Pennsylvania Hospital for training. Pennsy had long been a favorite clinical assignment for Penn medical students, and Kelley had become quite con-

cerned about having a sufficient number of patients in hospital beds to teach the school's medical students.[21]*

The Penn–Pennsy merger inaugurated a period of even greater red ink as the stars defected and disadvantageous contracts held, with the major insurers continuing to pay the hospital low rates. The health system now had to absorb Pennsy's losses on operations that climbed from an estimate of $10 million annually before the merger to $30 million by the end of the 1997 fiscal year. Furthermore, to complete the purchase, Penn agreed to allow the foundation, which operated the hospital, but would now become an independent entity, to keep $12 million of Pennsy's cash plus giving a promissory note for $16 million.[24] Including the cost of recruiting replacements for the defecting surgical stars and the additional operating losses, the Pennsy purchase cost the system a one-time expenditure of about $100 million.[25] Replacing the large admitters would prove even more expensive than at Presbyterian.[25] Peter DeAngelis, who became the health system's chief financial officer in January 2000, says, "In retrospect, with 20/20 hindsight, it's very easy to criticize the merger as it happened at a time when UPHS financial performance was already deteriorating quickly."[25]

With the merger, many of the Pennsy doctors feared that Kelley would insist that Pennsylvania Hospital become another CPUP hospital, where most of the doctors would be required to become full-time employees of the Clinical Practices of the University of Pennsylvania or leave. Dr. Michael Buckley, chairman of the department of medicine at Pennsy, remembers telling Kelley, "If you make us another CPUP place like Presbyterian, Pennsylvania Hospital will fail."[53]

At hospitals like Pennsy and Presbyterian, cardiologist Harvey Waxman has observed, the clinicians, driven to maintain their incomes, "live, eat, and breathe clinical care to satisfy patients, families, and referring MDs."[47] Chairs of clinical departments at university hospitals often presume that patients will come to their hospitals primarily because of their fame and reputation. Each sees his institution as another Mayo Clinic, attracting patients from throughout the region, if not the country and the world, primarily because of its name.

* The longtime affiliation with the Philadelphia Veterans Administration Hospital, where Penn taught a large portion of each class, was jeopardized by Allegheny's effort to control more of the services there. Penn and the Medical College of Pennsylvania, one of the schools Allegheny had absorbed, long shared direction of the medical and surgical services there. "We were a hair away from bailing out of the VA," Kelley remembers, "when Allegheny collapsed."[21]

Over the years, many of HUP's leaders had held this point of view, a questionable one even at such a well-known hospital as far as most of the admissions were concerned. "Patient care is local" applies to much of medical practice as it is said to characterize politics.

At Pennsylvania Hospital, "Bill's MO was not to promote superclinicians like Segal and [Dr. Frederick] Simeone," says Waxman, referring to the cardiologist whose practice, while he was there, sustained Presbyterian, and to the neurosurgeon whose loss to Pennsy, when it merged with Penn, cost the hospital dollars it could not afford to lose.[47] "The researchers who attend on the clinical services for one or two months a year," as do full-time faculty members like Kelley, when he supervised the care of patients earlier in his career, "don't build practices."[47]

Kelley, committed to not repeating the mistakes made at Presbyterian,[21] came to Pennsy and told the staff, "I won't screw it up, you're more efficient as you are," and stood by his word.[53] Kelley made good on his promise to recruit doctors to fill the void created by the departure of Pennsy's big admitters, a sizeable expense[66] that contributed to his later deficits. As one of the clinical chairs admitted, "We overextended ourselves. We were trying to do too much too soon."[67]

By 2000, private practitioners continued to develop 80 to 85 percent of the business in what is, in effect, a surgical, particularly orthopedic and neurosurgical, subspecialty and obstetrical hospital with assistance from the medical specialties and relatively little general medicine or surgery.[68] "Bones, brains, and babies" are Pennsy's specialties, it is said.[68]

Despite its past losses, however, Pennsylvania Hospital serves the health system in several ways. "HUP is becoming one gigantic transplant and intensive care hospital," says Buckley. "I think Pennsy is becoming an important additional place to train Penn residents. If they only work at HUP, their experiences would be too limited, especially in many of the surgical specialties."[53] Penn's new clinical chairs in neurosurgery and orthopedics have found the services at Pennsylvania Hospital so congenial that they do most of their operating there rather than at the university hospital.[53] "Access at HUP," where beds are usually filled, "can be horrendous," says Michael Buckley.[53]

Despite the problems with its new owner, Buckley believes that the association with Penn is essential for Pennsy's survival.[53] Pennsy carries $150 million of debt within the health system and, with little cash or endowment, could not survive long if it were independent. As for Penn selling the hospital, university

provost Dr. Robert Barchi wonders, "who would buy Pennsy with all that debt?"[69] "We can't stand alone and Penn won't let us go with anyone else," says Buckley. "I just hope the trustees won't pressure the health system to cut Pennsy loose."[53]

Phoenixville Hospital

The third hospital purchased by the health system is in the town of Phoenixville, forty miles northwest of Penn and part of the fastest-growing area in southeastern Pennsylvania. A local steel mill founded the hospital to care for injured workers in 1893 and, over the years, it grew into an acute care hospital with 175 beds.[70] A true community hospital, unlike Presbyterian and Pennsylvania hospitals, Phoenixville conducts no tertiary care and the physicians refer such work to other suburban hospitals or to the university hospitals in Philadelphia.[70]

On July 1, 1997, the foundation that operated Phoenixville sold the hospital to Penn.[71] To purchase the hospital, the health system transferred about $29 million of the hospital's cash reserves to the foundation, whose mission now changed to improving health care throughout the community, not just in the hospital. The hospital retained $18 million of its cash to support a similar amount of debt, which Penn now assumed.[70]

The university created a new six-member board for the Phoenixville Hospital with three of the members from the health system administration. The chair is local, a former member of the old board. There is also an advisory board, without voting power, its seven members recommended by the foundation and approved by the board. The fundamental authority resides at the university.[70]

Penn's buying the Phoenixville Hospital followed from its purchase, three years earlier, of Phoenixville Medical Associates (PMA),[72] a group of doctors described as the largest, nonfaculty multispecialty practice in the region.[70] PMA's members accounted for 65 to 70 percent of all admissions to the hospital, half directly, the remainder indirectly through referrals to the surgeons.

Phoenixville Medical Associates was founded and is still led by Dr. Joel Eisner, a general internist who, having moonlighted in the town during his residency, decided to settle there and started practicing as the town's first internist in 1969. Eisner became the hospital's chief of medicine two years later, a position he held until 2002. Then, in 1994, PMA, which now included thirty-

four doctors, joined Clinical Care Associates (CCA), the community-based organization Penn had created to operate the primary care practices it was buying.[73]

Eisner and Bud Pittinger, Kelley's number 2, had both grown up in nearby Pottstown. So when Pittinger and his colleagues began talking about how much Penn needed Eisner's group—for which the health system eventually paid $10 million—and how much good PMA could realize from the Penn relationship, Eisner listened with increasing interest.[73] After practicing small-town medicine for twenty-five years, Eisner saw himself participating in Kelley's exciting and booming enterprise. As leader of the largest group in CCA, Eisner would become a member of the CCA board. The health system would pay him, on a part-time basis, to be associate dean for regional clinical development and the medical school would appoint him clinical professor of medicine. His colleague, internist/cardiologist Paul Rogers, would become senior medical director of CCA.

The union of PMA, Phoenixville Hospital, and Penn, everyone hoped, would provide important advantages to all. Bringing in Phoenixville Medical Associates would provide Penn's new Clinical Care Associates with a large and successful group of primary care physicians in an important, growing suburban region where many hospitals had already formed links with other Philadelphia academic medical centers, particularly Jefferson. Since Penn then owned the largest group of doctors there, Kelley and his associates saw as logical owning the hospital whose admissions PMA dominated.

Phoenixville Hospital and the doctors liked the change because they saw Penn's helping them obtain managed care contracts and providing a prestigious connection to the region's leading academic medical center to which Penn hoped the physicians would direct their patients needing tertiary care. The Phoenixville staff and trustees had been worried that, if they did not join such a system, their hospital might not survive.[24,74] They also hoped that Penn would provide capital to improve their aging facility.[75] Kelley feared that, unless Penn linked with Phoenixville, Jefferson could dominate medicine throughout the western Main Line suburbs.[21]

Clinical Care Associates

Dr. Ronald Barg had been practicing general internal medicine in the Main Line suburb of Bala Cynwyd and admitting to the local community hospital for

more than ten years when Joel Eisner, in his role as associate dean for regional clinical development, approached Barg and his partner in 1994 about selling his practice to Penn's Clinical Care Associates. Like many of the other practitioners who joined CCA, Barg and his associates were concerned about being "locked out" from obtaining managed care contracts.[76] They anticipated that the contracts they might obtain would not be as valuable as those Penn could acquire. Barg also hoped to benefit from the economies of scale Penn's health system could bring to the operation of his practice. Furthermore, Barg realized that, if he were to sell, this was the time to do it. Other systems in the Philadelphia market were also bidding for primary care practices and the prices being paid, he suspected, were peaking.[76] Although some of the offers would have brought more capital to the practice, Barg's group decided to go with Penn and joined CCA on February 1, 1995. "We picked Penn because Penn seemed more solid, had greater vision, and would be more successful dealing with managed care than the other systems that had offered to take us on. I also wanted Penn to walk me through managed care, to pay for my learning curve."[76]

The first administrative leader of Clinical Care Associates was John Kepner, a Penn law school graduate and partner in a downtown Philadelphia law firm who had been practicing business and health care law for several years. Kepner had heard about some of Kelley's plans when the counsel at HUP sent him an outline of the strategy for the health system, and, he remembers thinking, "I thought this sleeping giant could really make an impact." Wanting to try a job in business, he accepted Kelley's invitation in 1993 to join the health system as executive director of CCA. Later, he became senior vice-president for network development and, eventually, for strategic initiatives.[77]

As Clinical Care Associates started in January 1994,[78] Kepner saw his charge designed as a marketing venture to promote HUP's specialized services "rather than strictly a capitation business."[77] However, its specific objective, as outlined to the trustees when Kelley sought their approval, was "to gain leverage with payers and contract for risk," Kepner explains. "Everyone in Philadelphia expected what was happening in California would sweep the East. If we couldn't obtain access to patients through managed care, we would enter a death spiral, become much less eminent, and attract poorer students."[77] Penn needed the CCA physicians to also train medical students whose curriculum now required more experience learning how to treat office patients.[21]

The university created CCA as a separate, not-for-profit entity so that suits directed against it and doctors employed in the network would not involve Penn.[77] Funding to purchase the practices was partly provided by surpluses

from operations.[51] Penn did not skimp on CCA, paying generously for the practices CCA was buying, similar to the amounts other health centers in the region were paying.[79] Purchasing the practices of 270 doctors, the maximum achieved, cost $55 million, which averages to slightly more than $200,000 per physician. Penn's goal was to buy only quality practices, the best in town.[47]

"This was a very exciting time," remembers Robert Field, a member of Kepner's group who located potential practices and helped negotiate the deals leading to their purchase. "The competition from the other health systems fed our intensity."[78] Field's job included coordinating teams that performed such administrative tasks as transferring the staff employed by the doctors on to the University of Pennsylvania payrolls, leasing or buying the offices, marketing and advertising the practices, transferring managed care contracts, centralizing billing procedures, and such details as developing signage and the letterheads on stationery and cards.[78] "We felt we were creating something that was where medicine was going. Penn was particularly well positioned to implement a new paradigm for health care based around primary care."[78]

Kelley, Kepner, Field, and their colleagues envisioned CCA's improving the quality of care while reducing costs through the use of up-to-date information systems, disease management programs, and health services research. Kelley also saw the CCA physicians as vital members of the faculty, their offices offering much-needed sites for the training of medical students in primary care.[80]

Before losses forced it to consolidate, CCA's 270 primary care physicians, the equivalent of 250 full-time doctors,[81] worked in seventy practices, each fully owned by the health system or a close affiliate, located in ninety clinical sites in five Pennsylvania and four New Jersey counties.[76] Most of the practices consisted of two or three physicians although some were larger like, for example, Phoenixville Medical Associates with more than thirty doctors, the first group to join CCA in 1993.[77]

During the first two years Ronald Barg's group was part of CCA, "the ride was very smooth," Barg remembers. "There was unlimited support for ancillary services and they spent lavishly to upgrade the offices. Penn was in an 'acquisition mode,' building as fast as possible regardless of expenses."[76] Barg felt no pressure to refer to HUP, where he had last worked while a medical student at Penn in the late 1970s. "We weren't made to feel that the primary motive was keeping HUP full."[76] Most of his referrals went to colleagues on the Main Line and at other teaching hospitals. "It was practice as you like to practice," he remembers. And the benefits for full-time CCA doctors were great. They

included support for the college tuition of dependents which, for a time, was more generous than that provided to full-time Penn faculty members working at the university campus.[82]

Hospital and Physician Affiliations

In addition to employing the CCA physicians, the health system also associated with about 200 physicians who would participate in full-risk contracts but without being Penn employees. Kelley also developed arrangements with several community hospitals in the Delaware Valley that did not involve changes in ownership. "We won't encroach on you if you won't go with Jefferson [or one of the other academic medical centers]," one senior health system administrator said when he explained the purpose of the system to the community hospital trustees who continued to operate their hospitals.[21]

Penn encouraged the CCA physicians to continue to admit most of their patients to their local community hospitals, but to send HUP the work appropriate for a teaching hospital.[79] Establishing arrangements to facilitate transferring patients from community hospitals to Penn, however, needed improvement. As is typical at many teaching hospitals, residents control many of the admissions through their assignments in the emergency departments or as the doctors-on-call for the different clinical services in the hospital. Keeping referring physicians pleased with HUP's desire to welcome potential transfers at all times was frequently not their first priority. Over the years, this behavior had contributed to the image of HUP as relatively uninterested in the problems of referring physicians.[79] Kelley insisted that all residents quickly admit every patient when so requested by a referring physician or a doctor working in the emergency department of a community hospital. If the house officer disagreed about a patient's suitability for admission, he was instructed to discuss the issue with Kelley himself. If more than ten minutes elapsed between the request for the referral and HUP's acceptance of the patient, the community doctor was encouraged to talk about the matter with the chair of the appropriate clinical department by calling him at his office or home or through his pager.[79]

Children's Hospital of Philadelphia

"The only thing Bill could have done but didn't," said one of Penn's leading scientists, "was to bring CHOP closer to the medical school,"[83] not that he did

not try.[84] CHOP is the Children's Hospital of Philadelphia, Penn's pediatric affiliate. Opened in 1855, the nation's first children's hospital, CHOP is now located adjacent to HUP in West Philadelphia. In the pecking orders that Kelley and other leaders in academic medicine follow so closely, only Boston Children's stands higher in NIH grants[85] and in *U.S. News & World Report*'s ranking of pediatric hospitals.[86] When Kelley arrived in 1989, Penn's pediatrics department at CHOP held a more exalted position in the NIH rankings than did any of the other Penn departments or the medical school as a whole.[87]

Since its founding, CHOP has been independently governed by its own board of managers even though Penn has long been its academic partner. Doctors working at CHOP have Penn faculty titles, and Penn medical students obtain most of their experience in the care of children there. Because of the governance structure, however, the CEO of the University of Pennsylvania Health System and Medical Center has no more control over the operations at CHOP than do the CEOs of the other teaching hospitals in Philadelphia. As dean, however, Kelley could influence, in partnership with the CEO of CHOP, which doctors would lead the medical departments at the children's hospital and decide what ranks they would hold in the Penn faculty.

Kelley's inability to bring CHOP more closely into his orbit particularly frustrated him. Especially infuriating was that CHOP, not the university, controlled its research funding[84] which, not incidentally, is conducted in buildings built and owned by CHOP. Penn faculty members working at CHOP apply for research support through CHOP and not through the medical school as do other members of the medical faculty. Consequently, the amount of these grants is not listed in Penn's total of NIH awards but rather in a separate table of independent hospitals that the NIH compiles. In the U.S. government fiscal year ending September 30, 2001, CHOP investigators generated more than $52 million in grants from the NIH.[85]

"Not having the CHOP research dollars drove him crazy," remembers Steven Altschuler, the former chair of the department of pediatrics at Penn and CEO of CHOP since 2000.[84] Particularly galling to Kelley was that if this amount were added to the medical school's total, Penn would surpass Hopkins and stand as number 1 in the list the NIH annually compiles about its funding to medical schools. The CHOP executives joined Kelley in trying to convince the NIH to change the rankings to benefit the university.[84] However, as long as the institutions were governed separately and the funds flowed into each independently, separate listing would continue.

Two other customs involving the pediatrics faculty irritated Kelley. CHOP, not the university, retained the funding for most of the endowed chairs held by Penn's academic pediatricians. Kelley argued strenuously with Edmond Notebaert, the CHOP CEO from 1987 to 2000, that endowments were traditionally university entities and that Penn should approve appointments of its faculty members to endowed chairs.[21] CHOP named all but three of the thirty-five pediatrics chairs "without university participation or approval," Kelley knew, "even though they were Penn faculty."[21*] Finally, the funds collected for the clinical work of the pediatricians in CHOP are not under the control of Kelley and the executives of CPUP, the practice plan for the other departments.[84]

Kelley tried but failed to change his differences with CHOP. When he finally realized that he would have to live with the status quo, the atmosphere improved. Notebaert rented him research space in one of the CHOP buildings while the new medical school laboratories were being built, and Kelley was invited to give the first annual Edmond F. Notebaert lecture in 1999.[84]

Radnor

Finding that outpatient facilities on the Penn campus severely inconvenienced many potential patients, Kelley and his associates decided to create professional office complexes in suburban areas where patients could be cared for by Penn physicians in comfortable surroundings near where they lived. Kelley's purpose was to bring more patients into the Penn system with the payoff in the form of "downstream revenue" when they needed procedures or admissions to HUP.[88] In establishing the Radnor facility, Kelley was following what his predecessor Edward Stemmler had built earlier when Penn developed its first satellite clinical facility in the suburb of King of Prussia.[89] Furthermore, the patients to be seen at Radnor—a community of affluent families—constituted a better payer mix of patients able to pay higher fees than many of those seeking care downtown.[90]

Although, originally, the health system considered building as many as four of these offices,[88] the major one now functioning is in the town of Radnor on the Main Line, where Penn had acquired the building formerly occupied by Walter Annenberg's Triangle Publications (*TV Guide, Philadelphia Inquirer*). The phrase, "nothing was spared," accurately describes the style Kelley had

* This unusual arrangement means that the holder of an endowed CHOP chair is titled the recipient of, for example, the "Jones chair in Pediatrics at the Children's Hospital of Philadelphia" and is not the "Jones Professor of Pediatrics in the University of Pennsylvania."

in mind for this suburban facility. The health system spent about $38 million to buy, redecorate, and equip the sprawling, four-storied office building. The extensive renovations led many observers to challenge the project as too expensive and overbuilt.[24,88] "We did it in a grand way with first-class finishes and comfortable exam rooms," explains Dr. Michael Grippi, the medical director at Radnor when it opened, "to create a gracious facility and not a bus terminal."[88]

From the time the Radnor project was announced, competitors challenged the enterprise. Using zoning restrictions, Jefferson, which, with several hospitals in the region, dominated much of the care, encouraged community resistance.[90] When Penn finally succeeded in opening the offices in November 1996,[91] office hours were limited from 8 A.M. to 7 P.M. Monday through Fridays, with the concession of 9 P.M. on Wednesdays and Saturdays from 8 A.M. to 1 P.M. Confining conscious sedation* to gastroenterology and dentistry effectively eliminated much same-day surgery, a rapidly growing method of delivering care,[90] contributing significantly to the losses the health system sustained at Radnor.[88] Zoning restrictions also prevented operating a pharmacy in the building, although the physical and occupational therapy units can conduct a full-service gymnasium.[90] These pressures led the health system executives to open the place as soon as possible and err in thinking too grandly. "We should have started out with less space for a small number of practices, hired fewer people, made our mistakes, and then grown," reflects Grippi.[88] Accepting, or not fully understanding, the effects of the zoning restrictions suggested to some observers that the initial business plan was faulty.[92]

One anxiety, however, did not materialize. Many feared that Radnor would drain off patients currently seen by Penn doctors in their offices at the medical center in West Philadelphia. Such transfers were unusual.[88] Most of the Radnor patients, now able to see Penn doctors in their new, pleasant, and more conveniently located offices, were new to Penn medicine.[88]

Kelley decided at the outset that full-time specialists from Penn, not doctors with community practices, should staff Radnor. He hoped to use the community facility, according to Grippi, "as a pilot to change CPUP into a multispecialty group practice."[88] However, patients and referring doctors did not favor the pattern of Penn specialists, working most of the time at the downtown campus, spending only a small amount of time at Radnor, one half-day

* During conscious sedation, drugs are administered that relieve anxiety and reduce pain without producing full unconsciousness. An anesthesiologist is not required to administer conscious sedation.

per week, for example. This custom and the unavailability of certain services at Radnor prevented the facility from operating economically.

By the fall of 1999, with the health system losses soaring, Kelley changed the financial and administrative arrangements between the health system and the clinical departments working at Radnor. When the offices there first opened, the health system indemnified the departments from losses and paid them to encourage participation in the venture. "Some departments pushed like good citizens, while others did not perceive enough financial incentive to do so," Grippi says. "There was little incentive for the departments to invest in laboratory services, encourage their doctors to work there, or operate efficiently."[88]

Under the new scheme, the health system stopped supporting most of the departments and delegated more responsibility to them. Now the practices keep the income their doctors earn but hire their own employees and pay for their expenses, including rent and management services.[90] The departments were encouraged to assign their physicians to Radnor for longer periods of time.[93] In some groups, physicians will spend nearly all their office hours there. "The itinerant model doesn't work," Michael Grippi says. "We should populate the place with docs who spend most of their time here,"[88] an approach to staffing the unit that Kelley says he had always favored.

Except for general internal medicine and general gynecology, the health system no longer directly subsidizes the services at Radnor. However, Penn does indirectly support the groups working at Radnor by charging only $17.25 per square foot (summer 2002) in a community "where the market rates range," according to Radnor administrator Michael George, "from $31–$35/sq ft."[90]

Despite the problems and the continuing losses, by the end of the 2002 fiscal year, patients were coming to Radnor at the rate of almost 160,000 visits annually.[94] Radnor's losses have substantially decreased from $13 million in 1998–1999 to $1.8 million in 2001–2002. If one excludes depreciation in the most recent year, the center would have produced a surplus of about $500,000. As a stand-alone venture, Radnor contributes, in downstream revenue, about $9 million annually to the health system's hospitals and practices.[94]

Clinical Practices of the University of Pennsylvania

At most academic medical centers, the management of the clinical practices of the full-time faculty has evolved into "practice plans," organizations of the practitioners designed to facilitate billing and collection of fees and to central-

ize decision making about the practices by the leaders of the departments and schools. These plans, often started by business-oriented section chiefs, were absorbed into departmental plans. In the final and the usual current arrangement, deans consolidated the divisional or department plans into the schools of medicine. These schoolwide plans are often directed by a committee of chairs, with the dean taking the type of role suited to his style of leadership.

At Penn, Edward Stemmler, whose term as dean began in 1975, completed the consolidation of most of the departmental practice plans by 1978 into what came to be called the Clinical Practices of the University of Pennsylvania, or CPUP, the practice organization of the full-time clinical faculty at Penn.[27,95] Not all departments came on board willingly, however. For many years, the department of surgery's plan remained independent, but, with the appointment of Dr. Clyde Barker as chair of the department in 1983, all but the most senior surgeons had joined the school's plan.[96]

Although, theoretically, the CPUP organization and the dean could set the agenda for the operation of the practices, the individual clinical chairs retained much of the power to run the practices in their departments. Every two years or so, the chairs elected one of their number to act as chair of CPUP. The vice-president for health affairs and the dean participated at a distance,[6] with Stemmler mostly taking the role of adviser.[96] Throughout the 1980s, CPUP lacked common programs or joint initiatives,[66] and the clinical chairs, "the dukes of the kingdom,"[15] dominated it. CPUP meetings were seen by some of the regular participants as "not very substantive."[96] One wag defined its limitations by saying that CPUP was an organization "linked together by a common heating system."[27,66]

With Kelley's arrival, however, this pattern began to change. Kelley demanded similar accounting, billing, scheduling, and practice-supported faculty benefits for all the departments. He insisted that CPUP and not the individual departments administer these programs.[66] Instituting the changes was "not too popular," Kelley remembers.[21] Most of the clinical chairs had zealously guarded their independent financial and administrative operations in the past.

By 2000, CPUP, prodded by Kelley, had reorganized into a practice organization with common rather than departmental goals.[66] The executive committee evolved into a decision-making body.[92] Centralized financial reporting, billing, and human resource policies had finally been instituted. Because of the high salaries being offered by the CEO of Allegheny, Kelley had to raise what he

paid to prevent clinicians with large and important practices from leaving. The range of salaries in one department had become so broad that "if it got out it would cause great distress in that department," said David Longnecker, chairman of the department of anesthesiology and of the CPUP executive committee beginning in 1997.[66]

The size of CPUP had also grown, adding expenses to the health system as income was dropping. From 1997 to 2000, the number of doctors in CPUP increased by one-third as additional full-time specialists were hired to replace doctors who had left Presbyterian and Pennsylvania hospitals when Penn bought them and to staff the satellite outpatient practice in the Radnor suburb.

The Audit

On December 11, 1995, the Office of the Inspector General (OIG) of the Department of Health and Human Services announced that CPUP would pay $30 million to settle a charge of false billing of Medicare by some of Penn's full-time physicians.[97] The government claimed that the doctors had overcharged for their services, submitted inadequate documentation, and billed for care they did not provide. "In many instances," according to an article in the *Philadelphia Inquirer,* "faculty doctors billed in their names for services that were provided by resident doctors in training."[97] The $30 million consisted of $10 million in false claims and overbilling and $20 million in penalties. CPUP denied any wrongdoing and agreed to the payment "to avoid the expense, burden, and uncertainty of litigation."[97]

John Harkins, an undergraduate and law school alumnus of Penn who served on the health system and university boards, strongly advised against the settlement, which he considered "too much and too precipitous."[98] As a litigator, Harkins believed that the government was not prepared to try the suit, that proving its case would have been difficult.[98] Kelley acknowledges not knowing, at the time, just what was the best thing to do. "They were tough," he describes the government lawyers with whom he was dealing. They threatened to "lay out all the dirty linen" if Penn did not accept the $30 million settlement. "I read Judy not wanting to fight and not wanting the publicity."[21]

Rodin, however, remembers differently. "I was strongly opposed to settling," she said.[99] Rodin had sought external advice, including that of David Boies, the renowned litigator, who also advised fighting the suit. Rodin claims that it was Kelley, not she, who wanted the settlement. "Bill thought the ex-

posure was too great." Rodin believes that Kelley favored settling because he "didn't want to take on the clinical chairs" in whose departments the billing errors claimed by the government had occurred.[99] If Rodin had this opinion at the time, according to Kelley, she did not clearly express it, and, as he recalls the event, she did not suggest that Penn fight the settlement.[80] Kelley now agrees with Harkins's views and thinks settling as Penn did was a mistake.[21]

Many at Penn speculated why their institution was the first chosen for the government's attention. HUP's profitability, following a dramatic turnaround, may have been one of the reasons.[100] A rumor making the rounds in legal circles attributed the selection of Penn to insufficient travel funds in the Inspector General's office in Philadelphia to try more distant cases.[98]

The OIG's experience with Penn inaugurated similar investigations at other academic medical centers, often leading to sizeable fines at a time when the income of full-time clinical faculty was coming under serious limitation.* To prevent inappropriate billing from recurring, which might bring further attention from the government, CPUP introduced additional administrative structures. Kelley increased his oversight in the management of CPUP to assure compliance with the federal government's regulations.[21] Many members of the clinical faculty, however, saw the new regulations as intrusive and expensive and complained about the inefficiency of the centralized billing service required by the settlement.[14]

Kelley remembers with some asperity that, because of the fine, Rodin threatened to withhold the bonuses of Kelley and two of his associates.[21] "Bill went ballistic about decreasing the bonuses," Rodin recalls. Although she wanted to withhold part of the bonuses in view of the large payments required by the settlement, "I paid them at the high levels the formula specified." According to the incentive plan then in force, Rodin believed she had to do this.[101]† The bonus question would arise again. When the operating losses grew, the president decreased what Kelley received according to a new incentive plan devised by the trustees. Only by Rodin's agreeing to also reduce what she received was further conflict avoided.[101]‡

* If Penn had not settled and had fought the suit with the legal power of Boies and Harkins, would the OIG have sued other academic medical centers later?

† Kelley was concerned that "reducing the bonuses for three specific individuals implied that they had some specific role in the government's allegations, which was not true."[102]

‡ As for salaries, Kelley was paid more than $1.3 million during 1998,[103] a figure not out of line with what CEOs of other large teaching hospitals were being paid. Rodin's salary and benefits during 1998–1999 of $655,557, less than half of Kelley's,[104] were the "highest of any college president in the

Overheads and the Flow of Money between Medical School and University

Medical schools generate more income from recovery of indirect costs than any other school in most universities with medical centers. This money derives from the practice of some granting agencies, particularly the NIH in the case of medical research, of paying the institution for the use of the facilities in which the research is conducted. An investigator applies for money to buy the supplies and equipment he needs for his work and, often, part of the salaries for himself and his laboratory assistants and fellows. A certain fraction of these direct costs may then be awarded to the university as indirect costs to support the infrastructure, the heat, light, and other basic needs of the laboratory. The management of what the indirect costs pay for arouses frequent complaints from the faculty in the basic science departments and the administration in the medical school. Based on what its members heard during their interviews, a committee reviewing one of the basic science departments wrote, "As best the committee could determine, this poor level of support seems to stem from the university at the administrative level."

The University of Pennsylvania, which recovers from all granting agencies an average of about 20 percent* of direct costs as indirect costs—$80 million in 2000—retains 20 percent of this money and returns 80 percent ($64 million in 2000) to the medical school which, of course, must pay for the services the indirect costs are designed to cover.[107]

Faculty members with some knowledge of the subject were led to believe that the university also taxed the health system to support projects of importance to the president and her colleagues, in particular, Rodin's enthusiasm for physical improvements on the campus and in West Philadelphia. In 1995–1996, she had instructed the health system to buy from the university the Blockley building, the Penn Tower (the hotel originally owned by Hilton across 34th Street from HUP), and the Penn Tower garage. Members of the medical school were then working in rented but unrenovated space in Blockley, formerly a nurses' residence, and clinics and executives occupied several of the floors of

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country," according to a survey in *The Chronicle of Higher Education* as reported by the *New York Times.*[105] Rodin has argued that her close supervision of the health system should be recognized in her compensation.[106]

* The NIH pays indirect costs particularly generously, in Penn's case, 58.5 percent of direct costs.[107]

the hotel for which the health system and the school also paid rent to the university. The university pressured the medical center, as Kelley saw it, to pay about $75 million for properties that independent estimators told Kelley were worth about $25 million on the market.[106] "You're doing this to shift money from us to the university," Kelley remembers telling Rodin, but he swallowed hard and accepted the arrangement partly because the health system was so profitable at the time.[21] A trustee told Kelley that the maneuver was similar to a company's moving money from a wealthy subsidiary into the parent corporation, "but," Kelley adds, " we got no help in the other direction later [when the health system started losing money]."[21]

The university saw the deal as appropriate and fair and suggests that Kelley was engaging in revisionism in condemning the trade five years after it had occurred.[51] "We got the approval of the health system executive committee," remembers John Fry, the university executive vice-president, "as well as the facilities and the budget and finance committees and then the full board of the university." The university also "obtained an independent appraisal of the property that supported the transaction value."[51]

Kelley saw the flow of funds across Spruce Street in stark terms. "We moved close to $100 million per year, a total of $900 million, to the university during my time, most of it after Judy arrived," he claims, "and this didn't include such capital expenditures as the new research buildings. Suffice it to say, she did not like it when I told her that the goose that laid the golden egg was anovulatory [no longer producing eggs]. This was after several years of more gentle verbiage. When I started pushing on this, Judy balked."[21]* Kelley would come to believe that his pressure for a reevaluation of the health system-to-university flow of dollars "was another major factor in her decision to fire me."[21]

The health system and the university differed about the appropriateness of the amount of the overheads, and assembled conflicting data to support their positions. Kelley claimed that the whole medical enterprise paid significantly more to the university than did several competitive academic medical centers, none of which sent more than $50 million per year to their universities.[21] "We were charged double what steam, telephone, and electricity cost and paid all the taxes levied against the university."[21]

* Penn medical loyalists call Spruce Street "a semipermeable membrane with cash flowing north to the university and exudate ["pus" to the laity] flowing south to the medical center."[13] Some suggested, particularly after the losses developed, that by insisting on the transfer of funds the university caused "massive internal bleeding" at the health system.[21]

Kelley and his colleague Richard Tannen had analyzed data from the top seven private medical schools in the United States, and from this study, concluded that at Penn, "100 percent more dollars flowed from the school of medicine to the university than at any other top medical school."[108] John Fry countered that consultants that the university had retained to review the overheads said the amount was reasonable, not out of proportion to what happened at other universities with academic medical centers.[65] "It is fundamentally incorrect," adds Fry, "to leave the impression that the university benefited from these transfers, when, in fact, these funds were used either to pay direct costs incurred by the university or represented funds transferred from one part of the health system to benefit another component." Kelley points out that, if this were true, "these were the direct costs of the entire university, not just the school of medicine."[108]

Rodin, Kelley said, instructed him not to discuss with members of the health system board the flow of dollars from the health system to the school of medicine, directions that Rodin denies ever giving to Kelley.[99] Much as he may have disagreed with her, however, Kelley, who told one of the trustees, "Judy will fire me if I talk," knew that he worked for Rodin.

How to divide the indirect costs and how much the health system and school of medicine should contribute to the university's overhead provide much opportunity for deans and presidents to disagree. When the health system was flush, the differences between what Kelley would pay and what the university wanted seemed less controversial. When the bad times arrived and Kelley wanted back some of his contributions to the university to relieve the deficits in the health system and school of medicine, one can easily imagine the intensity of the negotiations between the leaders in Penn Tower and College Hall.

Building Research Programs

Despite the growing financial and administrative uncertainties that were beginning to plague Kelley, all acknowledge that, as dean, he transformed the nation's oldest school into one of the best. Before Kelley arrived, a committee established by the provost had demonstrated that, in the medical school, the basic sciences were "not holding their own in grants," according to Dr. Perry Molinoff, then chair of the department of pharmacology, who led one of several committees appointed at the time to study how the university could improve its scientific work in the life sciences.[109] A department with few grants

usually suggests that the faculty in the department are not producing particularly noteworthy research or that there are few members in the group compared with their peer institutions or both.

Leaders of the top schools use the ranking of grants and contracts awarded by the NIH as a guide to their school's standing versus their competitors. In 1989, Penn stood 9th among 124 of the country's medical schools—not bad, but not good enough for Kelley. While he was chair of the department of internal medicine at Michigan from 1975 to 1989, the department's annual total research funding rose from $2 million to $42 million and the department's rank in the NIH list from 42nd to 4th. His faculty expanded from 131 to 238 members.[21] At Penn, Kelley would lead the school to second position in the NIH list in both 1998 and 1999, exceeded only by Johns Hopkins.[110*] Total research funding would grow from $102 million in 1989 to $304 million in 1999[21] as the NIH portion swelled from $82 million to $238 million during the same period.[111] Since the number of faculty members grew by only 29 percent, Kelley could claim that the results reflected "a dramatic increase in the productivity of our faculty."[21] His trustee colleagues agreed. Roy Vagelos praised Kelley for "transforming science and research" at Penn. "He recruited very well, and the people did extraordinarily well."[112]

On one measure of the excellence of the research conducted at Penn, however, Kelley was to remain disappointed throughout his tenure—the number of members of the faculty elected to the National Academy of Sciences. When he left the leadership, twelve members of the medical faculty were members of the academy, but several were emeritus and only three were elected while Kelley was working at Penn. (This number compares with more than twenty each at such schools as Harvard, Stanford, and the University of California, San Francisco.) The relative dearth of academy members reflects what Leslie Dutton, chairman of the department of biochemistry, refers to as Penn's insecurity.†

* Harvard Medical School is actually number 1, with twice as much NIH research funding as Hopkins. It stands 19th because the research conducted in its affiliated hospitals is not listed with the medical school.[110]

Kelley made sure that this writer was aware that, during the fiscal year ending September 2001, Penn brought in more money for research grants from the National Institutes of Health than did Hopkins. It did not advance in the rankings because Hopkins received more money in contracts.[21]

† Dutton, a British subject, is a fellow of the Royal Society, the British honorary association for scientists, which, having been founded in 1666, started electing members 200 years before the academy. Britton Chance, the second Penn fellow of the Royal Society, is one of its eighty foreign members.[113]

"The place is parochial. It has a nouveau riche feel about it. We've grown up very quickly."[113] The size of the Penn contingent reflects, in part, Kelley explains, the relative weakness of basic science at Penn in the 1970s and 1980s,[21] and the youth of many of the recent recruits whose work merited support from the NIH but had not yet met the standard that brought election to the academy. Kelley also felt that Penn had not yet developed the political connections and consequent clout in the academy that would assist the election of Penn's qualified candidates.[113] However, in the Institute of Medicine, the branch of the National Academy of Sciences for leaders in academic medicine, Penn had forty-six members in the summer of 2000, second only to Harvard, according to Kelley.[21]

"Education is always number 1 on my list," says Kelley, "but to have that, clinical and research must be superb."[21] Kelley knew that to have the best research, the university needed an outstanding faculty and that "the currency was space even more than money."[21] When Kelley arrived at Penn, he found space in the medical school "unbelievably awful, especially for research. So a major thrust was to build research space."[21,114] Penn needed, Kelley believed, 600,000 to 700,000 square feet of research space, a total of one million square feet throughout the medical center, including that in the Children's Hospital of Philadelphia, Penn's governmentally separate pediatric affiliate.[21]

Despite his enthusiasm for education, most observers believe that building Penn's research programs was Kelley's primary goal, for he knew that, in academic circles, investigative prowess brought a medical school its greatest acclaim. The preamble to the 1990 report of the Life Sciences Committee, which stated[115] "Penn's standing as a scholarly enterprise of the first rank is fundamentally dependent on the vitality of its research enterprise," certainly expressed the priorities of the new dean. Kelley charged this committee, also chaired by Molinoff, to develop a programmatic rather than departmental approach to the development of research in the medical school.[115] The group recommended that the school emphasize the following topics: aging, biology of cancer, developmental biology, genome mapping, human gene therapy, molecular genetics, neurosciences, retrovirology (which includes the type of agent causing AIDS), and structural biology.

To ensure that the committee's deliberations would prompt the school to accomplish his goal of taking Penn to the top of the top 10 in research, Kelley assumed a leading role, described as "dominant, aggressive, and assertive" by one of the participants.[116] Molinoff saw Kelley making a definitive choice that

the medical school's science must grow aggressively, lest it remain mediocre. "He used the committee's recommendations widely," Molinoff remembers, and he met with Molinoff frequently as the committee was deliberating and the report was being prepared.[109] From reading the relevant section of the report, one detects Kelley's influence in the exposition of the case for developing human gene therapy, his favorite subject.

Kelley also arranged, through a small planning group, that faculty laboratories be consolidated, whenever practical, around individual departments, bringing together investigators whose close collaboration would benefit their work. He tried to match the capacity of the buildings to the programs being developed. Many of the older structures, one of which was built almost a century earlier, were converted from research laboratories into offices and teaching space; renovating them into contemporary laboratories would have been prohibitively expensive.[116]

For this ambitious program to succeed, more laboratory buildings would be needed. The Clinical Research Building had opened in 1989, Kelley's first year at Penn, but its capacity alone could not take the medical school to the heights Kelley envisioned for it. Accordingly, during the next ten years, the medical center built two research buildings funded, for the most part, from the proceeds HUP was generating.[29] The names for the buildings attest that no single donor came forward to pay for them. The ten-storied BRB-I, which opened in July 1994 with 78,000 net square feet,[117] was named the Stellar–Chance Laboratories in honor of the late Dr. Eliot Stellar, a renowned Penn neuroscientist and former provost of the university,[118] and Dr. Britton Chance, one of Penn's most distinguished scientists who directed for many years the Johnson Foundation for Medical Biophysics. Faculty from both basic science and clinical departments worked in the new laboratories, of which the new Institute for Human Gene Therapy had 17,000 square feet.

The latest addition is called BRB II/III, the combination of plans for two buildings that were put together when funds to build the two phases became available and estimates demonstrated that a single tall tower would cost less than two smaller buildings. BRB II/III, which cost $148 million for its fourteen stories, opened in April 1999 and was quickly occupied. Several unique architectural features of the building brought visitors from other academic medical centers to examine what some call "the house that Kelley built," since he took a major role in developing how the internal structure would work and assuring an agreeable ambience throughout the building and its surroundings.[116] Dur-

ing the 1990s, the Kelley years, the amount of research space for investigators in the University of Pennsylvania school of medicine almost doubled, from 482,000 to 874,000 net square feet, and this figure did not include the laboratories of the department of pediatrics based at the Children's Hospital.[21]

Recruiting Faculty

With new buildings coming on line, Kelley engaged in the activity he may most enjoy and, most agree, performs with great skill. He recruited new faculty, an occupation for which he has "impeccable academic taste," his nemesis across Spruce Street, university president Judith Rodin, readily concedes.[45] Whereas his predecessor, Edward Stemmler, had limited the size of the faculty, Kelley felt no such restriction and recruited enthusiastically and continuously.[119] Insisting that Penn only recruit candidates of outstanding accomplishment or promise, he personally reviewed every nominee for appointment for tenure or within a tenure track and frequently[40,120] and always tried to attend the seminars given by prospective recruits.[17] Other than for chairs, Kelley favored recruiting junior faculty because, as he told the chair of a basic science department, "There are so many bright young people."[40]

The Kelley recruiting style, "very different from the way Penn used to do it," as one of the chairs commented,[68] can be difficult to resist.[121] Prospects for senior positions usually flew into Philadelphia, where they were greeted either by Henry Williams, Kelley's director of special projects, or, in Williams's absence, by a chauffeur who swept the candidates to the campus or to the first-class hotel where they stayed. "When you've been through busy days, you need comfort," Williams explains when asked why Kelley always recruited first-class. "The extra dollars for the Ritz-Carlton or Four Seasons are insignificant, given the potential impact each chair or senior executive might have on the institution. When you are recruiting world-class candidates, you must provide world-class accommodations."[122]

When hiring at the chair level, Kelley appointed search committees that culled the field and sent him three or more choices to choose from. Each candidate received, before his first visit, a document describing in detail the organization, governance, finances, personnel, and space plus the current research, educational, and clinical (if a clinical department) facilities of the department. The document also described the new provisions to be made

available for the prospective chair, including the number of new faculty positions, the laboratory and clinical space, startup funds, and the salary and benefits for the successful candidate. Staff from Kelley's office escorted the candidates around the campus, according to a detailed itinerary received before the visit, showing them the facilities and introducing them to the faculty, including Kelley, who would interview them. Business conducted over meals occurred at, what Williams describes as, "very high quality restaurants."[122]

When recruiting chairs, Kelley would then visit the finalists at their universities, usually spending about half a day with each candidate.[122] This custom, leaders in academic medical centers will recognize, is distinctly unusual;* most of those who appoint senior faculty seldom make such trips. In explaining his reasons for doing so, Kelley says, "I often didn't know who they were, or what they did, or what they were really like. I wanted to see them on their home grounds."[21] Kelley remembers how these trips revealed to him the type of people he would want or not want. A cardiologist being considered for a senior position did not know where his hospital's intensive care unit was. That was the end of him. The score on a candidate for a department chair rose significantly as the visiting Kelley observed that everyone seemed to know the nominee, who exchanged friendly greetings with many members of the staff and employees as they toured his hospital. "A tremendous community citizen—a great plus," Kelley concluded.[21]

Recruiting chairs and institute or center directors was Kelley's highest priority. He told the leaders of his faculty, "Find the best and recruit them."[123] "I got unbelievable chairs," he believes, and adds, in explaining why he gave so much effort to this work, "Mistakes can last for ten years."[21] Most came from institutions other than Penn and relatively few from Kelley's previous institution[40] despite some sniping about the Michigan mafia's effect on the traditions of the nation's first medical school.

Kelley seldom suggested candidates and relied on his search committees to find the best people, consistent with his basic nature of being "very process-oriented," as Henry Williams repeatedly observed.[122] Sometimes, however, Kelley rejected the recommendations of his committees and either instructed their members to find more candidates or formed another committee. Kelley

* Roy Vagelos, who, earlier in his career, had chaired a department of biochemistry in a well-known medical school, said, "Visiting on site is something I'd never seen a dean do before Kelley. He conducted the most diligent searches I've ever seen and made very few mistakes."[112]

had not used search committees to locate potential division heads when he was chair of the department of internal medicine at Michigan. He looked around himself, using his large network of fellow academic leaders throughout the country. In the Penn job, he had no choice, since the university required that search committees nominate candidates for chairs. Furthermore, in appointing chairs for some of the departments, he needed help locating and evaluating prospects because even the polymath who is Kelley was not expert in every medical discipline. In the opinion of Tachi Yamada and others, "Kelley was an excellent judge of people and had very good scientific taste. Bill's motto was, 'Never trust anyone else when you're recruiting'."[17]

The recruitment offers for chairs were, of course, larger and more complex than for other faculty. In every case, Kelley and his staff had prepared the offer in advance of the search itself,[109] tailoring the packages to what he had concluded the leading candidate would need to do his job successfully within the limitations of the space and money available to him. Knowing what he could offer, Kelley presented the offer to the candidate as soon as he had decided on his choice, unlike most academic recruiters, including the dean who preceded him at Penn,[109] who accepted the choice of the search committee, asked what the candidate wanted, and then tried to develop the resources that he needed. "That's it," Kelley would say. "We shouldn't go further if this doesn't meet your expectations and needs."[21] In two or three cases he did increase the original package, but not by much. Salary for recruits was seldom a problem. Each knew about what private universities paid, but if the candidate balked, Kelley might sweeten the compensation modestly if he was sure this was the best person. Additional salary sufficient to land a potential winner came to many fewer dollars than agreeing to hire another faculty member or another technician, allocate more laboratory space, or purchase another piece of expensive equipment.[21]

A typical example of the Kelley technique brought Dr. Priscilla Schaffer to Penn to chair the basic science department of microbiology in July 1996. Schaffer, who was chief of the division of molecular genetics at the Dana-Farber Cancer Institute in Boston, was much in demand for a job of this sort. Until the Penn proposal, she had turned down eighteen similar offers during the previous seven years. Schaffer was the sixth woman to be tenured at the Harvard Medical School, where she held the title of professor of microbiology and molecular genetics.[124]

When the search committee recommended Schaffer, Kelley visited her in Boston. "He came to my office at the appointed time—I had not met him before—and talked with me about my operation," she remembers. He asked why she was interested in running the department at Penn. "I told him I wanted to stretch myself. I wanted to be a chair and put myself on a new learning curve." Kelley produced a letter and said, "You're my first choice. Sign it!"[124] "We discussed each item," says Schaffer, "and I asked lots of questions." After another visit to Penn, she accepted the job with few changes. "Who could refuse Bill's offer? It was incredibly generous compared with other offers." There was plenty of lab space and money to recruit up to nine new assistant professors. "I was very impressed by the collegial nature of the place. It was almost too good to be true."[124]

Dr. Haig Kazazian had known Kelley at the NIH in the 1960s and interviewed with him when Michigan was trying to recruit Kazazian to lead genetics while Kelley was chairman of medicine in Ann Arbor. Kazazian, a pediatrician, was a twenty-four-year veteran of Johns Hopkins and director of the center for medical genetics there in 1994 when Kelley considered him for the chairmanship of the department of genetics at Penn, one of the relatively few medical schools with a department in this rapidly growing scientific subject.[125] "He had three names and visited me at Hopkins to see what I was up to and what the rest of the division looked like," remembers Kazazian.[125] Kelley selected Kazazian, made him a "very good offer, and I took it."[125] Kazazian found Penn "more collegial than Hopkins. The number of large egos was fewer here. At Hopkins, you're expected to make a big mark, so you wind up with some skewed personalities. It's easier to get things done here [at Penn]."[125]

Kelley's role in recruiting faculty other than chairs and directors was less direct. His insistence on the highest quality, however, permeated the departments, centers, and institutes.* In the department of medicine, for example, the largest department in most schools, Dr. Edward Holmes, Kelley's choice as chair, started in July 1991 with a department of about 170 faculty members.

* Centers and institutes were favorite Kelley structures in which, unrestrained by traditional departmental or divisional boundaries, investigators could conduct research and, in particular, translational research whereby the discoveries in the basic science laboratories are applied to clinical medicine.[126] These organizations also gave him the opportunity of expanding the number of responsible leadership positions to faculty members, not department chairs or division chiefs, who would then assume titles as center and institute directors. During his tenure, Kelley created twelve new centers and institutes, led by senior faculty members who reported directly to him.[21]

Believing the "triple threat"* no longer existed in academic medicine, Holmes recruited internists to fill particular roles such as laboratory investigator, clinical investigator, or clinician. Of course, all were expected to teach. Saying "we want you to be successful but you need to focus your work," Holmes expected faculty members to eventually support themselves for about 80 percent of their time by obtaining grants if investigators or by generating practice income if clinicians.[67]

During the six years that he was chair at Penn, Holmes and his division heads recruited more than ninety investigators and clinicians. About 30 to 40 percent of the faculty he inherited required what Holmes calls "reorientation,"[67] a process that led to the departure of several "to pursue other options."[67] By the time Holmes left Penn in 1997, the departmental faculty had increased to about 230 full-time members, ten of the twelve division heads had changed, and research and clinical productivity had significantly increased.[67] Although the CEO/dean had most recently been a department of medicine chair himself, Kelley did not interfere in the development of the department at Penn, says Holmes. "I reviewed with him what was going on; once or twice a year. Bill provided guidance but never micromanaged,"[67] a point of view not shared by all members of the faculty and university administrators.

Even with the extraordinary growth in competitive research money that Kelley's recruits generated, the school of medicine continued to have to support about half of the salaries of faculty with tenure track appointments in the basic science departments. As the health system's finances worsened in the late 1990s, Kelley continued to insist, as he always had "as a matter of principle,"[108] that the scientists support at least 80 percent of their compensation—which approximated the portion of their time spent on research—plus all the expenses of operating their laboratories. To accomplish this required that investigators hold at least two NIH grants simultaneously.[127] Department and center directors were expected to run a program project grant in addition. Medical faculty will appreciate the difficulty of meeting these expectations. Grants were thus a fundamental feature of the professional life of each investigator. As one basic science chair told faculty members asking about the security of their positions: "Your security is your grants."[128]

* The "triple threat," which some think is a mythical creature, refers to the academic physician who excels equally as an investigator, clinician, and teacher. With the increasing specialization of science and clinical medicine, even the most able faculty members find it impossible to perform with similar skill in each of these roles.

Although Perry Molinoff saw Kelley as "very hard on the clinical departments," he was "incredibly supporting of the basic sciences."[109] Even as a relatively senior chair with no promises left from his recruitment, Molinoff, with Kelley's help, improved the pharmacology department so that the NIH ranking of the department among the nation's medical schools rose from 70th when Molinoff became chair in 1981, eight years before Kelley came to Penn, to 6th in 1994 when he left Penn for a senior job at a pharmaceutical company. "I recruited an average of two new professors each year until I left. I would send him a request for a three-year budget for up to $700,000 to hire a faculty investigator. Twenty-four hours later, I had my approval." Had Kelley studied the proposal? Molinoff remembers that when Kelley questioned the travel allowance for a candidate, Molinoff realized he had incorrectly budgeted for the current choice the relatively large amount needed by a previous recruit who had to commute to California to conduct some of her research. Kelley and/or his staff had found the mistake within one working day.

Keeping first-rate investigators rivaled in importance recruiting new researchers to Penn, and Kelley conducted this work with enthusiasm and skill. Luigi Mastroianni, the former chair of obstetrics and gynecology, remembers with gratitude Kelley's help in retaining his most productive investigator. "It was the summer and I was in Wood's Hole [a research laboratory in Massachusetts] when I heard about my colleague's having received a very attractive offer." Mastroianni called Kelley at his vacation house in Michigan. "Bill fixed it," and the investigator stayed at Penn, Mastroianni remembers with satisfaction.[27]

Kelley saw developing basic science at Penn as one of his most important goals. Using the Molinoff report as a guide, he budgeted a total of $350 million to increase the size of the basic science faculty from 100 to 140, build the new laboratories, and renovate the old buildings at a cost of between $10 and $15 million per year.[29] Soon after Kelley arrived at Penn, he established the academic development fund (ADF), which received half of the surpluses developed by HUP. The hospital's extraordinary profitability for several years during the early and mid-1990s gave Kelley the money to recruit investigators, equip and staff their laboratories, and construct the new buildings that the research enterprise required.[122] The remainder of the surpluses plus borrowed money were spent to improve the hospital facilities, buy the primary care practices and community hospitals, and acquire and equip the Radnor practice site.

Accordingly, the leaders and members of the basic science departments,

particularly those who joined Penn during the Kelley years, greatly appreciated what he was doing to improve the medical science at the university. Even though Kelley was not a Ph.D. and his career had not progressed through a basic science department, faculty members in those departments praised Kelley's efforts and, for obvious reasons, preferred his decisions to those of his predecessors, who were seen as favoring the clinical departments over basic science.[129]

Education

Kelley continuously claimed that education was his highest priority and that improving research and clinical care principally served to support the teaching mission. Nevertheless, the research buildings were rising, many of the investigators had been hired, and the health system had been created before Kelley directed his attention to the primary reason that medical schools exist: to train students to become doctors. He chose Dr. Gail Morrison to lead this effort. Morrison is a nephrologist who had coordinated the student teaching programs in the department of medicine since 1986. In 1995, Kelley appointed her vice-dean for education for the medical school and said to her, "Do what is needed. I want the best education program you and faculty can develop. If it's too expensive or too political, let me deal with that."[21]

After several retreats and conferences with chairs and many members of the faculty, Morrison and her associates developed a sequence of teaching they called "Curriculum 2000." Kelley gave practical support to this effort by making $1 million available to Morrison for each of three years for teaching equipment, information services, and salaries for faculty. Proud of this accomplishment, Kelley believes the Penn curriculum is "way ahead of other people."[21] Despite his enthusiasm, however, the new program did not start until August 1997, eight years into his deanship at Penn.

Nevertheless, Curriculum 2000 appears to have been well received by the students and faculty, increasing, Morrison believes, the popularity of attending Penn. To fill the class of 150 in 1995, the admissions office offered positions to 360 applicants, whereas in 1999 with the new program in place, 263 offers were needed for a class of the same size.[130] How much of this gain in competitiveness was due to the new curriculum and how much to Penn's rising reputation in research and clinical care is difficult to determine.

In keeping with Kelly's emphasis on science, he encouraged expansion of

the M.D./Ph.D. program, whereby medical students obtained the senior research degree while receiving their medical training. This program, supported by NIH funding, prepared students for careers in medical research through devoting several more years to their doctoral training. By 2000, about 20 percent of each class of Penn medical students was enrolled in the M.D./Ph.D. program, making it the largest and one of the most competitive in the country, according to Kelley.[117]

Kelley always claimed that providing teaching sites for medical students was his primary reason for building CCA and buying the primary care practices. According to Dr. Malcolm Cox, associate dean and director of the office of network and primary care education, about one-fifth of the students by the 2000–2001 academic year—the school's goal is 50 percent—took their introduction to clinical medicine course with CCA doctors in their offices.[131] For their clinical clerkships, the fundamental clinical course, the students spend increasingly more time training with practitioners who work in offices away from the medical center. Although Cox joins many other faculty members in believing that Kelley really established CCA to "capture patients and feed them in [to HUP]," participation of the primary care physicians in education has now become essential for the training of medical students to practice contemporary medicine in the community. Each CCA doctor must agree to spend at least 10 percent of the time teaching.[131] All that teach competently may receive Penn faculty appointments.[108]

"Bill's given too little credit about education reform," says Cox about Kelley's role in the effort. "He gave it a legitimacy by cloaking himself in it."[131] With respect to the changes Gail Morrison and her colleagues patiently pursued through what seemed like endless meetings, Kelley "kept a massive food fight from breaking out," Cox believes, as basic science chairs fought for preservation of their traditional access to the students. "Bill was essential—the ultimate guardian that it would happen."[131]

Pittinger Leaves

At 6:30 on the evening of January 25, 1995, HUP security guards escorted Bud Pittinger, the executive director of HUP and senior vice-president for health services in the University of Pennsylvania Health System, from his office.[132] The reasons behind this ignominious conclusion to Pittinger's five years at Penn puzzled many. Some thought Kelley and Pittinger could not

agree on the terms for renewing Pittinger's five-year contract. Others saw this unlikely in view of the close, long-term relationship of the two and the fundamental role Pittinger had played in reversing HUP's losses and helping to produce the surpluses that Kelley had spent to improve the medical school's research potency and develop the health system. An important reason, which Kelley and Pittinger have never discussed, relates to the perception of Pittinger's style of operation by several of the leading doctors and administrators.

When Pittinger and Kelley arrived at Penn, HUP was losing money, and the new team had to prevent overspending, an obligation not guaranteed to win friends. As HUP's finances turned around, Kelley delegated increasingly more administrative responsibilities to Pittinger, whom he appointed chief operating officer of the health system in addition to his original job as executive director of HUP. Pittinger thus became his number 2 for the nonacademic part of his combined job of CEO/dean. "Bud controlled everything," one of the participants explained. "Although very efficient, he micromanaged everything," and became increasingly seen as insulating the medical and administrative leaders from Kelley. Another senior hospital executive found Penn a tightly controlled environment, with Kelley not encouraging discussion and Pittinger secretive, a characterization of himself that Pittinger adamantly denies being true.[18,20]

By 1994, according to several sources, opposition to Pittinger's style and authority was spreading. Some of the more influential chairs made Kelley aware that they were less than happy with the chief operating officer's growing dominance. "Bud had a style," Edward Holmes, the chair of the department of medicine, said, "which meant that he wanted to be informed before we went to Bill, and we felt that *we* reported to Bill."[67]

Some of the chairs were concerned that Pittinger, who insists that this was not his intent,[18] might develop a network of specialists through CCA, which he supervised. "Specialty medical care is the mission of the [full-time] faculty," said Holmes, who was then chair of CPEC, the executive committee of the faculty practice plan. The clinical chairs did not look with equanimity on the possibility of a group of specialists, tied to Clinical Care Associates, usurping an important mission of the school of medicine during a time of limited resources.[67]

In other respects, however, the clinical chairs were very pleased that the

health system had developed CCA—"a godsend," as Homes put it—for it removed from his department the responsibility of funding additional primary care practices, an expensive and unprofitable enterprise for academic departments.[67] The economics of primary care in medical schools seldom allows divisions of general internal medicine to break even or produce a surplus; almost all require financial assistance.[81]

It was time for Pittinger's contract to be renewed. Several observers heard that Pittinger's requirements were stated in the form of an ultimatum. As one former administrator said, "You don't give Bill an ultimatum." Neither Kelley nor Pittinger will elaborate much further in describing what came between them except for Kelley to say "we failed to communicate as well as we had. The chairs and Bud were growing in their jobs, and Bud was feeling more independent. The chairs had been unaccustomed to being run by Bud. Their objections did enter into my thinking."[21]

Trustees and other corporate leaders whom he knew advised that, if Pittinger had to go, it should be done quickly with security standing by. "It was supposed to be subtle," Kelley explains, "but it wasn't. The whole thing was to protect Bud as well as us, but it wasn't handled well."[21] Threatening litigation, Pittinger was given a settlement which those with knowledge of the details thought exceedingly generous. One member of the executive committee of the health system board said, "Bill was very upset by the firing. He had enormous difficulty doing it."[106]

Observers, recognizing the significance of Pittinger's leaving, commented, "Bud carried Bill's water,"[133] and "off goes Bud, and Bill has no Bud." Kelley, now "without heft at the top," as Judith Rodin describes the health system without a chief operating officer,[45] found himself directly exposed to all the problems from which Pittinger had shielded him.[28] In time, Kelley would understand the importance of losing Pittinger, saying, "My biggest mistake was not solving the difficulties I had with Bud."[21]* When Gordon Williams, the much admired[22,134] senior administrator who was described as someone "who

* Pittinger, who subsequently worked for several well-known pharmaceutical houses, most recently Merck, believes that it was time for him to move on anyway. "When I left the provider side, I didn't look back," he explains. "I love the pharmaceutical business. It wouldn't have been good for me to stay in academic medicine because of where it has gone. I moved out at just the right time."[18] The close friendship between Kelley and Pittinger continues despite the circumstances under which Pittinger left Penn. "I wouldn't be where I am today," he says, "without Bill's continuous support, and I'm tremendously grateful to him for helping my career. That's where my heart is."[18]

knew how to cut through the red tape and get things done,"[15] left a year later, many saw this change as the beginning of something fundamental. "When Gordon leaves," the CEO at CHOP was heard to say, "I know it's over." By the spring of 1996, Kelley was perceived to be, as more than one participant observed, "alone."

CHAPTER FOUR

Kelley in Trouble

As he approached 60 years of age, William Kelley could look with satisfaction on his accomplishments at the University of Pennsylvania since starting there on October 1, 1989. With the help of his longtime friend and colleague, Bud Pittinger, the Hospital of the University of Pennsylvania had generated large surpluses, allowing Kelley to build a medical establishment with a size and complexity previously unknown at Penn. He had bought three hospitals and the practices of 270 primary care physicians and had constructed a system to service the capitated contracts that he and many others believed would dominate the economics of health care for many years. By directing half of the surpluses from HUP into the academic development fund for the medical school, Kelley had recruited superb scientists and clinicians, developed contemporary research programs, and constructed new buildings at the medical center and the suburbs for clinical work and research. He had sponsored a comprehensive revision of the curriculum for the increasingly competitive students Penn's medical school now attracted.

Kelley had constructed what Pittinger called "an unbelievable academic engine" and made Penn "one of the great leaders in academic medicine."[1]

Those who have known Kelley throughout his career were not surprised that he had accomplished so much for Penn medicine, and similarly, would understand why he reacted as he did when the troubles descended on him.

Kelley's Education and Experiences before Penn

William Nimmons Kelley was born in Atlanta, Georgia, on June 23, 1939, six days before his father began his internship. Oscar Lee Kelley had just received his M.D. degree from Emory University, where both he and eventually his son would attend college and medical school.

After completing his hospital training and briefly holding a job with the prison system in Florida, Kelley's father moved the family to Palm Beach to begin practicing as one of eight physicians in the county. Then came three-and-a-half years in the Army Air Corps during World War II. His specialty training, taken after the war, consisted of an eight-week cardiology program at one of the Harvard hospitals. William Kelley remembers accompanying his father to Boston for the course.* By 1946, Oscar Kelley was again practicing in Florida. "He took me for house calls in his Model A Ford," Kelley remembers. "We were often paid in eggs and oranges."[2] Not all of the senior Kelley's patients, however, paid with produce. During the winter when wealthy families came south to their mansions, Kelley's father cared for several of them and imported surgeons from distant medical schools to perform well-paid operations on his winter clients.

"I never thought of doing anything other than medicine," says Kelley, whose father taught him how to insert intravenous lines as a teenager.[2] Graduating from Palm Beach High School in 1956, Kelley attended his father's college and medical school. "Emory's the only place I'll pay for," his father told him, and that is the only medical school to which he applied.[2] Since Emory, unlike some other universities, did not award a degree at the completion of the first year in professional school to students like Kelley, who transferred from the undergraduate college after three years, Kelley has no bachelor's degree.† By 1963,

* Now a cardiologist takes three or more years of fellowship after three years of internship and residency in medicine before qualifying to practice the specialty.

† William N. Kelley: undergraduate, 1956–1959, M.D., 1963, Emory; medical intern and resident, Parkland Hospital, Dallas, 1963–1965; fellow, National Institute of Arthritis and Metabolic Disease, National Institutes of Health, 1965–1967; senior resident, Massachusetts General Hospital, 1967–1968; assistant professor to professor of medicine, chief, division of rheumatic and genetic diseases, Duke, 1968–1975; chair, department of internal medicine, Michigan, 1975–1989; executive vice-president, 1989–2000, dean, school of medicine, 1989–2000, chief executive officer, Medical Center,

when he became a doctor, Kelley had married Lois Faville, the daughter of close family friends whom he had first met in kindergarten, and was by then the mother of two of his four children.

Kelley's father had long planned that Bill would join him in practice after completing his training, but an experience in a research laboratory at Emory changed that. The visit to Emory by a medical scientist from the University of Texas Southwestern Medical School at Dallas convinced Kelley to apply for internship and residency at Parkland Hospital, the principal training hospital for that school. He was accepted, and came under the influence of Dr. Donald Seldin, the chairman of the department of medicine at Southwestern and the first of his faculty mentors. Kelley says about his relationship with Seldin, as those who know Kelley would expect, "Unlike most of the rest of the interns, I wasn't intimidated by Seldin, who would question us each day at our conference with him."[2] Kelley, intensely interested in current medical research, found himself well prepared to answer the questions Seldin was likely to ask. Seldin, effectively the founder of the department of medicine at this post–World War II medical school, made it a practice to groom leading students and trainees for faculty positions in his department. Impressed by Kelley's intelligence and interest in research, he arranged that Kelley receive laboratory training at the NIH before returning to join the Southwestern faculty.

As a fellow in the laboratory of Dr. J. Edwin Seegmiller in the Section on Human Biochemical Genetics of the National Institute of Arthritis and Metabolic Diseases, Kelley studied the metabolism of uric acid, the level of which is elevated in the blood of patients with gout and in children with the rare Lesch-Nyhan syndrome, a genetically determined disease characterized by severe hyperuricemia (high levels of uric acid in the blood), mental retardation, and self-mutilation.[3] Kelley and Seegmiller discovered that these children lack the enzyme hypoxanthine phosphoribosyltransferase (HPRT), which accounts for the overproduction of uric acid and hyperuricemia in these patients. The partial deficiency of this enzyme, which produces gout but no mental abnormalities, is known as the Kelley–Seegmiller syndrome.[4,5]*

Kelley's experience at the NIH set the pattern for his further career, which

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1989–2000, and Health System, 1993–2000, professor of medicine, 2000-present, all at the University of Pennsylvania.

* Seegmiller, research professor of medicine at the University of California, San Diego, when interviewed in 2001, remembers Kelley when a NIH research fellow in the 1960s as "very knowledgeable, very directed, with lots of ability and working long hours. He was always asking questions of Mother Nature."[5]

did not include joining his father in practice (and "which Dad never forgave me for," Kelley notes).[2] During 1967–1968, Kelley took a third year of house staff training as a senior resident at the Massachusetts General Hospital in Boston. It then became time to return to Southwestern as programmed by Donald Seldin. However, by now, Kelley had decided that his research should emphasize the new field of human biochemical genetics, and not nephrology,* which Seldin had in mind for him. He therefore accepted a job at the Duke University medical school, where the new chairman of the department of medicine, Dr. James Wyngaarden,† was also an investigator of gout and other metabolic diseases. Kelley quickly established a highly productive research laboratory[6] there and soon obtained funding from the NIH. One year after Kelley arriving in Durham, Wyngaarden named him chief of the division of rheumatic and genetic diseases. Kelley had requested that the word *genetic* be inserted in the title to indicate the importance of this discipline in clinical medicine. Kelley speedily advanced from assistant to full professor of medicine. Consistently supported by competitive grants from the NIH, he studied further the metabolism of purine metabolites, of which uric acid is one, and rapidly became recognized as an authority in the field.

Never formally qualified in his specialty, Kelley self-trained himself in clinical rheumatology. "I was never a great clinician, so I let the great clinicians teach me."[2] Wyngaarden remembers challenging Kelley, whose early years at Duke had been spent principally in the research laboratory and not in the clinic: "Within two years, you have to become the best rheumatologist in the section."[6] As would be expected of Kelley, "he took the challenge, rose to it, and became a very effective teacher and energetic on the wards."[6] For his research, Wyngaarden recalls, "he got very good people for his laboratory and did a marvelous job training them.[6] Kelley would later appoint one of his former trainees, Edward Holmes, chair of the department of medicine at Penn.

As his administrative responsibilities at Duke and activities outside the university grew, Kelley, like many investigators, delegated much of the day-to-day work within the laboratory to his junior associates and trainees and indirectly coordinated the research from his office. "Since I'm not at the bench anymore, I might as well be an administrator," he said in explaining one reason why he began looking at chairmanships of medicine.[2] While on sabbatical

* Nephrologists study and treat patients with kidney disease.

† Wyngaarden had just returned to Duke after a short tour as chairman of the department of medicine at Penn (1965–1967).

leave at Oxford University in 1974, the University of Michigan in Ann Arbor approached him about just such a job, which he accepted starting in August 1975. Unlike many chairmen burdened with the administrative responsibilities of the job, Kelley reestablished his research laboratory at Michigan and led it with continuous grant support during his fourteen years and two months there. One of his most productive trainees and associates at the time was Dr. James M. Wilson, whom Kelley would recruit to Penn to establish a large laboratory for the study and treatment of genetic diseases. In addition to issuing continuous reports on research in his laboratory, Kelley and associates published, in 1981, the first edition of the *Textbook of Rheumatology,* which has become the standard work in the field. In 1989, he brought out the first edition of his *Textbook of Internal Medicine.*

By the end of the 1980s, Kelley had decided he had done all he could to develop programs at Michigan. "People were getting tired of our success," he remembers thinking. "Internal medicine stood number 4 in the NIH listings. No other department at Michigan was in the top 10."[2] Blocked from receiving additional departmental space or money from the medical school or advancement for himself at Michigan, Kelley looked at senior jobs at other academic medical centers, was offered several, and finally chose Penn in the summer of 1989.

Kelley's Characteristics

As is the case for many forceful leaders, everyone at Kelley's institution has something to say about the boss.[6-46] All acknowledge his being visionary, more specifically, visionary with a focus, and no one doubts his high intelligence. Frequently used descriptions of his characteristics include ambitious, brilliant, charismatic, effective, efficient, energetic, forward-thinking and willing to take risks, imaginative, optimistic, tenacious, an activist with unusual drive, truly committed to academic medicine, even heroic and awesome, a giant of a man, a larger than life person, "in a league of his own as a thinker, a recruiter, a scientist and organizer"; "when he walks into a room, he takes over because he's quicker and smarter than anyone else there."

While leading strongly, Kelley liked to adhere to routine. "He worked everything through his processes," says Henry Williams, "whether dealing with his leading academics, the health system, the university administration, or the trustees. From day one," adds Williams, "Kelley was oriented to governance. If

there was an issue he would face up to it, even with his board." This practice would soon be tested as the health system began to lose money.[18]

Kelley's work habits became legendary. "We'd be here at 7 A.M.," says Williams, whose office was nearby on the twenty-first floor of the Penn Tower hotel. "No time was unscheduled. He'd go nonstop. He was never inaccessible, even when away. He'd call continuously from airplanes and hotels."[18] Kelley gave about two lectures per month at other institutions, Williams remembers, but was away from Penn less than one-third of the time.[18] Kelley was renowned for processing information quickly. "We'd send him home with one or two bags of work," says Williams, "and everything would be done by the next morning despite a dinner engagement."[18] As a boss for a staff person, Henry Williams says, "he was perfect. He gave you guidance and direction and expressed his decisions clearly. If you asked a question, you got an answer. He stretched you to do more than you thought you could do."[18]

Dr. William Kissick remembers being told about Kelley's remarkable work habits during a trip in Asia. "After long days of site-visiting research institutes and a belated dinner, Bill would check with the concierge at the hotel and receive a FedEx box." Kelley would review the reports and memoranda during the night and, the next morning, return the box to Philadelphia. "This routing persisted for the entire trip."[47]

Kelley was admired for his decisiveness and ability to think quantitatively, two of his many skills as an administrator often lacking in other academics.[24] Mark Kelley, who worked closely with William Kelley for nine years,* saw him "exuding confidence, always in control and rarely [but certainly sometimes according to other members of the faculty] losing his temper."[48] Another colleague said that the "good thing about working with Bill was that when he wanted something done, it happened, and he wanted it done yesterday." The chair of a basic science department added, "I found Kelley's hard-driving leadership refreshing when compared with a place at which I used to work." Most hold that Kelley, whatever his faults, was a very effective leader.

Many on the faculty praised his support for their scientific efforts. "I'd send Bill a copy of a paper I'd published in *Science* or *Nature* [two of the most competitive journals for medical scientific work]," says Leslie Dutton, chair of the department of biochemistry. "He'd always respond, often with 'I liked it'

* The two Kelleys are unrelated. William Kelley's son, however, is William Mark Kelley, who goes by the name Mark.[2]

and his signature. He really knew what you were doing."[49]* Saying "I learned how to manage from Bill,"[49] Dutton was not alone in gaining from his experiences working with Kelley. Most of the chairs described him as excellent to work for. Michael Mennuti, the head of obstetrics and gynecology, calls him "a fabulous boss. I always knew what he wanted of me."[42] One member of the senior faculty observed, "He's upfront, and he keeps his word." Another added, "You can't fault him for lack of candor."

His former Michigan colleague, Tachi Yamada, found "his expectations for you were always clear, and if you lived up to them, you were rewarded."[28] Yamada was young, just one year out of his fellowship at UCLA, when Kelley first tried to recruit him as chief of gastroenterology at Michigan. When Yamada decided to stay in California, Kelley told him, "You're the guy I want, and I'm keeping the job open for you."[28] A year later, when another senior job was offered, Yamada, remembering his favorable impression of Kelley, who had visited him in Los Angeles to sell him on Michigan previously, phoned and asked if the job was still open. It was, and Yamada moved to Ann Arbor.[28] Yamada believes that Kelley's recruitment of him was typical of the Kelley technique. "He was willing to make the leap and gamble on me, willing to create the right package and willing to wait. He follows up on everything and often overdelivers."[28]

Kelley brought to Penn the high standards that have always been a feature of his leadership. "Bill never compromises on quality and would not accept anyone less than the tops," said one of his former division heads at the University of Michigan.[43] "If you wanted to promote an inside person, you'd really have to push since he always wanted you to sweat and get the best person available.'If you can't do it, I'll find someone who can,' he would say."[43] Accordingly, Kelley was well known for "lacking patience with people not doing their jobs." However, no colleagues or observers questioned the outstanding quality of Kelley's values, academic and otherwise. They see him as having "high integrity" and "a moral compass" and as "committed to the core missions of academic medical centers." Most would agree with the description of Kelley as "honest, always doing the right thing and never vulgar."

Not everyone, however, had unbridled praise for the boss. Many found

* "But Kelley's not an intellectual," adds this British-born and -educated amateur artist and regular reader of the *New York Review of Books* and the *Times Literary Supplement.* "I'm really more a painter than a scientist," Dutton admits, despite his well-recognized accomplishments in the experimental laboratory.[49]

him aggressive, commanding, dominating, controlling everything, and always pushing the envelope. Others described him as autocratic, arrogant, imperious, impetuous, inflexible once he makes up his mind, intense, intimidating, and inconsiderate of other people's feelings, mean-spirited, even megalomaniacal with grandiose ideas. Kelley caused fear, whether meaning to or not, in many who dealt with him. "People are afraid of him," summarizes what numerous colleagues said about him. Others commented, with some exaggeration, "He created an atmosphere of respect and terror, that there was a microphone in the room and that no one should cross him." A senior professor claimed that Kelley's motto was "*L'état, c'est moi,*"* not "I'm here to serve you." One found him "a kind of cowboy." Few saw Kelley, the hard taskmaster, as "warm and fluffy. He doesn't like to schmooze with people. Everything's cut and dried." "Bill was very slow to confide and trust in people," his close associate Gordon Williams believes. "A consultant told Bud Pittinger and me that our biggest job was to control Kelley."[27]

Kelley did not like hearing bad news, and, one professor observed, the messenger might suffer for bringing it to him. Kelley "couldn't take the affection of the chairs and make the most of it," one administrator observed. When there was trouble, "he'd call in the chairs and pound the table and say'fix this,' like Dad pounding on the table."

Several of the most senior members of the faculty disliked Kelley's apparent inability to listen well. A faculty member with decades of experience at Penn noted that when a speaker suggested something, Kelley might be inwardly thinking, "Who could have had those thoughts I haven't thought about?" and added, "If he didn't want to hear it, he didn't hear it."

In Kelley's time, many employees were forced to leave Penn. "He would love us at the beginning, but then, it would change," remembers one of the former members of his staff. "We came to wonder, 'Whose turn is it next?' " Contemporaries criticized Kelley's firings as "not very graceful." Paradoxically, Kelley was also censured for keeping people around too long. "If he has one weakness," suggests Gail Morrison, who saw much of Kelley in her role of vice-dean for education, "he wants to believe in people longer than he should. He doesn't like to give people bad news,"[24] which may help to explain his difficulty in letting people down comfortably.

Although one of his colleagues could see Kelley as "head of GM as well as a

* Literally, "The state. It is I."—attributed to King Louis XIV of France.

hospital," another found that his "biggest weakness is that he's not a businessman." His close associate, Wilbur Pittinger, disagrees. "Bill does not lack for business acumen. He's as good with numbers and financials as anyone I've worked for. He's not as good when it comes to organizational management," the function that Pittinger and other senior colleagues performed for him.[1,27] Kelley came to agree with this assessment.[2] At one aspect of running a business, however, Kelley was seen as very skilled. Very "image conscious," he was a "master spinner."*

Kelley was much censured for uncritically accepting the advice of consultants in the early 1990s, which led to the creation of, and exorbitant staffing of, the health system. "Bill didn't apply the same critical appraisal to the consultants' data as he had throughout his career to scientific data," says Dr. Sanford ("Sandy") Schwartz, a Penn professor who works in health care delivery and has trained and holds faculty appointments in both the school of medicine and the Wharton School.[16]

Faculty in the Wharton School complained that Kelley made little use of the expertise of the members of its Leonard Davis Institute of Health Economics. "I once asked Kelley to let us study what he did and give him some research input," remembered Professor Robert Burns in the department of health care systems. "The health system is a natural lab for Wharton to study. He responded, 'You are welcome to come in and study us after we have succeeded'."[50] Kelley said that he told Burns, "We need to get the job done before we divert our focus."[51] Burns's students did collect one year of data on Clinical Care Associates. "The docs there said that education was at the bottom of the list despite what Kelley said." Burns then added, "Kelley didn't want us to report this. What an attitude, remarkably short-sighted."[50]

Professor Bernard Bloom, a health services researcher with appointments in both the school of medicine and Wharton, believes that, in not seeking help from colleagues at Wharton, Kelley and his associates made a serious mistake. "They never walked across that canyon, Spruce Street, to ask the faculty at Wharton for help on financing, operations, and business management." The

* Kelley exercised great care that his points of view were fully expressed in these chapters. After interviewing him twice face to face, I sent to him, as I did for each of the major players in this tale, the entire manuscript for review and correction. Kelley and I then spoke thirteen times on the telephone and exchanged four e-mails. I wrote in many of his subsequent comments about material in the text, sometimes as footnotes, but deleted no substantive material, including quotations that might cause him discomfort. I thank him for accepting this arrangement.

leadership at the health system was "great with medicine, poor in marrying medicine with management."[52] Kelley responds that the Leonard Davis Institute does "fantastic work, but they weren't very helpful in what we were doing."[2]

Despite these observations about Kelley's imperfections, several members of the faculty concluded that only someone with Kelly's methods of management, both those admired and disparaged, could have brought Penn medicine so far. "Although some people have called him and his management style arrogant," suggests Dr. Sankey Williams, chief of the division of general internal medicine, "I can't imagine changes like those at Penn done by someone less forceful than Bill."[53] Nick Bryan, the chair of radiology and one of Kelley's last recruits, observed, "No guts, no glory, but then, I'm used to Debakey," referring to surgeon Michael Debakey, who dominated the Baylor medical center in Houston for decades.[35] The results of Kelley's tenure could not be denied, despite his faults. "He took a quiet, sleepy Quaker school to the top," said a senior faculty member.

"He has Napoleonic features that merge with his vision and accomplishments," suggests Garret FitzGerald, chair of the department of pharmacology. "Time will provide a fairer appraisal of his incredible vision and commitment to academics."[54] Scientist Britton Chance, a member of the medical school faculty since the 1940s, concluded, "The Kelley years brought a revival of the esprit de corps we had lost."[55]

Bringing Kelley both praise and criticism, his style of leadership was seen as the antithesis of that of his predecessor, Edward Stemmler, the dean from 1974 to 1988.[12,26,34,41,55-58] Unlike Kelley, who first came to Penn in 1989, Stemmler was a Pennsylvania veteran, working continuously for the medical school and its affiliates since he had entered as a student in 1956. Colleagues saw Stemmler as bright, thoughtful, agreeable, quietly effective in getting things done, but cautious and not instinctually a rebel. He conveyed confidence that Penn medicine was flourishing and doing what the university wanted. Stemmler's management style was low-key, unaggressive, and easygoing and emphasized collegiality, consensus, and accessibility. He governed through committees and task forces to reach decisions in the approved academic fashion. At Penn "forever," Stemmler was seen as attached to and loving everybody, but, according to one observer, "he could get buried in the trees."

Whereas Stemmler seldom attended meetings of CPEC,[57,59] the executive committee of CPUP, and left most of the decisions to the clinical chairs, Kelley

dominated this group.[34,60] Under the new regime, although CPEC continued to meet, the Kelley administration now made the important decisions affecting the operation of the practices unilaterally, or so it appeared to some of its chairs. "CPEC went from a body that took an active role in the institution," remembers Leonard Jarett, former chair of the department of pathology and laboratory medicine, "to one that became a Friday morning breakfast club when Kelley announced what had to be done."[10]

The fate of the photographs of Jarett's successors attests to the diminution in their authority. Tucked away in a corner of the entrance foyer of Alumni Hall, HUP's principal auditorium, are pictures of the CPEC chairs beginning in 1976. The last portrait shows the incumbent during 1989, the year Kelley arrived. These pictures once adorned a more prominent location on the wall of the principal HUP conference room in which CPEC, the hospital board, and other senior groups held their meetings.[34]

Kelley developed specific strategic plans, not a feature of previous medical school administrations.[12] His meetings with the departmental chairs were more tightly organized, more efficient, everything planned "to the minute," more "agenda-driven" than in the past.[33,46] Similarly, when evaluating administrators, Kelley would emphasize and reward increasing volumes, net operating income, and the effectiveness of the specific responsibility of the administrator such as, in the case of the director of human relations, recruiting superior personnel and decreasing the cost of workers' compensation. Kelley's trustees strongly approved of this approach to the management of his academic and business colleagues.

Consequently, as Dr. Clyde Barker, leader of the department of surgery and, by the end of the 1990s, the longest-serving departmental chair, observed, "Things were decided before they got to a forum where there might be objections."[33] When Penn bought Presbyterian and Pennsylvania hospitals, the clinical leadership was informed but not involved in making the decision, "an example of the centralization of power under Kelley," Barker said.[33] "He would just announce, 'This group of doctors is coming here' or 'I just bought this hospital,' " remembers Leonard Jarett.[10] Priscilla Schaffer, chair of the department of microbiology, recalls several of her colleagues trying to convince him not to buy more hospitals. "He blocked it out. What they said didn't register."[44] Kelley, however, asserts that he encouraged the members of CPEC, the faculty practice's management committee, to discuss and debate his most controversial plans.[2] He was further advised by a steering committee of chairmen, which

included the leaders of two of the basic science departments, which met with him every other week to review issues of primary importance to the medical center.[61] Clearly, however, unlike former dean Edward Stemmler, Kelley led more by executive authority than by consensus.

When Kelley needed money, both soon after he started and in his later years at Penn, he appropriated reserves that clinical departments had developed. Leonard Jarett was particularly upset by these maneuvers. "He took $92 million from clinical practices in his last year, including $27 million from our funds and $44 million from radiology," Jarett claims. "All gone. I moved $13 million into endowments in the medical school to prevent his appropriating it."[10] Kelley responds that, when the losses had reduced the health system's cash, he had to preserve the departmental reserves to satisfy the debt covenants. "The money was never taken away, but frozen from being spent." He planned to allow the departments to spend the money after the system was no longer losing money.[2]

Forcing his colleagues to accept each of his decisions was not as consistent a policy as some of Kelley's critics claimed. It was true that Kelley's instinctual response to an idea that ran counter to his plans was rejection. Later, however, after further thought, he could change his opinion. For example, Kelley wanted to institute in all the clinical departments restrictive covenants that would have prohibited clinicians, if they left Penn, from practicing locally and competing with their former employer. Many of the clinical chairs objected, claiming that the restrictions would interfere with recruitment. When the members of the faculty senate heard about the covenants, "they were very upset," according to one observer.[62] "I hear you," Henry Williams remembers Kelley saying, and "he backed off," allowing the individual departments to choose whether to use restrictive covenants when appointing clinicians.[18] As this episode suggests, "Kelley learned from his mistakes and avoided repeating his errors," says Richard Tannen, his chief of nephrology at Michigan and later a senior member in the Penn dean's office. "He doesn't think he's always right."[63]

The Losses Begin

By the 1997 fiscal year, it was clear that the surpluses at HUP were ending. The insurers were bearing down, forcing providers like Penn's four hospitals and its doctors to accept less money for their services. The advantageous Blue

Cross contract had ended, and that dominant insurer, through a new contract, was paying HUP significantly less than previously. Pittinger, now gone from Penn for two years, had warned about the earlier contract: "when it goes away, watch out!"[62]

For what capitation there was, the insurers, by withholding necessary information and timely information, prevented the providers from effectively managing the risk,[48] which led some of his trustees and administrators to advise Kelley against accepting such contracts.[2] Furthermore, the same insurers appeared to be passing on to the hospitals and doctors their own financial problems by paying bills late and by delaying payment of legitimate claims, denying payments for medically necessary services, and/or arbitrarily downgrading levels of care.[64*] Finally, according to Andrew Wigglesworth, president of the Delaware Valley Healthcare Council, "the financial condition of hospitals and health systems was further stressed by growing levels of uncompensated care, the introduction of mandatory managed care under Medicaid, elimination of Medicaid coverage for the General Assistance population, repeal of CON ["certificates of need," required for hospitals to build expensive facilities like cardiac catheterization laboratories], and ongoing Medicare cuts at the federal level."[64]

Then came the Balanced Budget Act in 1997, with its reductions in Medicare payments, delivering the "lethal injection to a very sick patient," as Dr. Mark Kelley, vice-dean for clinical affairs throughout the 1990s, dramatically described what the federal cuts meant to the finances of Penn's already struggling teaching hospital.[48] Some of the patients on Medicare were now using managed care contracts, and the amount of this lower-paying version of one of the hospital's best payers was growing.[69] In Pennsylvania, the amount of uncompensated care that the Penn hospitals provided to needy patients was rising.[70]

For whatever consolation it provided to the troubled executives, Penn was not alone with its financial woes. In the fiscal year ending June 30, 1999, nearly 60 percent of hospitals in Philadelphia, almost half of suburban hospitals in southeastern Pennsylvania, and 40 percent of hospitals throughout the state

* This is an accusation that Independence Blue Cross, the largest insurer in the region, adamantly denies. "To blame their problems on our payments is a travesty. Billing was abysmal at Penn," said John A. Daddis,[65] senior vice-president, managed care and operations, during an interview with this writer conducted with G. Fred DiBona, the CEO, John C. Zamzow, senior vice-president, contracting and provider networks, Dr. Gary M. Owens, vice-president, patient care management, and Daddis at Blue Cross headquarters in Philadelphia during November 2000.[65-68]

lost money.[70] Despite Penn's losses, however, HUP's occupancy stayed high. Since increasing volumes had always been the answer for hospital losses in the past, this pattern particularly worried the health system executives. Kelley would need to deal with a financial reality unknown to Penn medicine during most of his reign. In the year ending June 30, 1997, the health system would lose, on operations, $15 million,[71] then $90 million in the next year,[71] and $198 million during fiscal 1999.

Kelley continued to make investments, but, as the market turned against him, Penn could no longer support them.[39] Despite the falling income, for all too long, he would persist in spending and building as he had in the days of the surpluses. Kelley later acknowledged that he and his colleagues had responded too slowly to the rapidly changing financial picture.[2] Some of his trustees had advised, earlier in the 1990s, that Kelley save some of the surpluses rather than spending and borrowing so much money to buy practices and hospitals for the health system and recruit faculty and build laboratories for the medical school.[72] "With an endowment of more than $1.3 billion in the health system and over $800 million in cash reserves," Kelley believed, "I was following this sage advice as well as I could until the'perfect storm' hit in the marketplace."[51]

Hospital Purchases

As the losses mounted, executives of the health system renewed their objections to buying Presbyterian, Pennsylvania and Phoenixville hospitals. As for Presbyterian, "Why would anyone want to buy an undernourished hospital in a depressed area of the city that had few of the characteristics of a primary care hospital anyway?" said critics when reviewing that purchase.[73] Presbyterian was purchased as "a marketplace defensive item. It just came up," remembers John Kepner, the senior vice-president for strategy and acquisitions from 1993 to 1999. "The purchase was undertaken quickly and secretively, and financial discipline was lacking. The attitude seemed to be that since we had been so successful, and we were the best, Penn could make Presbyterian work."[74*]

As trustee Roy Vagelos remembers the events, "Bill said, 'I've got to have that hospital. It's in our back yard.' We never discussed that revenues might have tanked. Here was the guy who had the golden touch," and the trustees did not interfere.[75]

* Kelley agrees that acquiring hospitals was not part of the initial plan, and "that is why we acquired many fewer hospitals than our major competitors, Jefferson and Allegheny."[51]

"We took on so many hospitals in such a short time, we couldn't do what had to be done so fast," says Richard Tannen. "Consultants told us to take a deep breath and consolidate. It wasn't possible."[63] Although Kelley would be faulted, either wholly or in part, for these purchases, each was approved at the time by the president and executive vice-president of the university and the trustees responsible for the health system and the university.[76]

Clinical Care Associates

At CCA, the future envisioned for the network of primary care physicians appeared less bright than initially envisioned, supporting the conclusion of some that the concept upon which Kelley had built CCA was flawed.[77] The centralized billing system was not functioning as well as the method clinicians like Ronald Barg had formerly used in their offices, and the income derived from laboratory work was disappearing into the health system's consolidated program. The health system was encouraging its physicians to send their patients' blood tests to the clinical laboratory at HUP rather than do them in their offices or send them to a nearby commercial lab. Since the equipment in the Penn labs was then underutilized, this work provided significant surplus for the hospital.[78]

At HUP, several of the clinical chairs objected to the amount of money CCA was draining from their projects. HUP executives preferred improving facilities like the operating rooms, cardiology laboratories, and computer facilities.[79] "There was a clear philosophical difference," says Kepner. "We were trying to build a corporate culture for CCA with the Penn academic culture on top. This produced macrocultural problems."[74]

Many of the primary care physicians whose practices Penn had bought were not producing at the rate the health system had projected. Now employed full-time by the big university, part of their incentive to practice efficiently and wholeheartedly was gone.[80,81] The insurers who had assigned the control of expenditures to physicians found that "it didn't work," said Sankey Williams. "Doctors working with risk contracts don't make money, in fact, in many cases, they lose money."[53]

John Kepner, who led the effort to acquire the practices for CCA, was criticized for the money spent to bring many of the doctors into CCA. "The amount we paid for the practices was less than most people thought," says Kepner when accused of overspending, a charge frequently directed at Kelley

and his associates. "The prices were fueled as much by community hospitals having a lot to lose as by Allegheny or Jefferson."[74] Contributing to the problems in CCA, some of the doctors worked so far from West Philadelphia as to discourage referring all but the most severely ill patients to HUP.[45,82] Several of the physicians who joined CCA had previously been hostile to Penn. Some were graduates or trainees of other medical schools in Philadelphia that traditionally competed with Penn. They joined, Michael Mennuti, the obstetrics and gynecology chair, believes, "because they were scared or didn't like the other choices."[42]

In addition to providing a means of obtaining capitated contracts and providing educational opportunities for Penn students, Kelley anticipated the CCA practices becoming, as he told his trustees, "an important part of the health system."[61] By tying primary care physicians to Penn, he anticipated that referrals to his hospitals, particularly HUP, would rise, helping to produce surpluses that could fund improvements in the medical school.[83] He told his trustees that he expected that CCA doctors as a group could ultimately refer as many as 20 percent of their patients to Penn facilities.[81] Data supporting the success of this aim, however, are difficult to find. The health system estimated that CCA doctors contributed $109 million in collections during 2000, equal to about 5 percent of the total income of the health system. Kelley acknowledges that referrals had not, as yet, met his expectations, "primarily because they are heavily dependent on the quality of service, which never became good enough to be attractive to the primary care physicians."[61]

Some members of the faculty thought that Kelley's hopes for CCA as a source for patients at HUP were overly optimistic. "Patients go local for their secondary and tertiary care," said Harvey Waxman, the chief of cardiology at Presbyterian. Since the primary care practices lose money by themselves, "you lose both dollars and the patients. HUP would have gotten the top-end business anyway."[45] John Hirshfeld, the HUP cath lab director, agrees. "No more than 10 percent of HUP's business in cardiology comes from CCA doctors and the primary care network."[41] Hirshfeld's laboratories continue to be busy because of the relationships he and his colleagues have developed over the years with internists and cardiologists who are not part of the health system network or CCA.[41] "It takes about five busy primary care physicians to keep one adult cardiologist busy," says Michael Parmacek, the chief of cardiology at HUP, "and most of the CCA doctors' cardiac patients do not come to Penn. We estimate that 90 percent of their cardiology goes elsewhere."[84] Bruce Rosen-

gard, a cardiac surgeon recruited from Hopkins, agrees. "CCA and the hospitals [Presbyterian, Pennsylvania, and Phoenixville] have not substantially increased referrals to us." The growing reputation in the community of surgeons his division had recruited plus the willingness of HUP doctors to undertake complicated treatments on patients at high risk helps to keep the hospital full.[85] Part of the problem reflects one of the features characteristic of the nature of many physicians. "You can't herd doctors," observes Dr. Mitchell Blutt, a university trustee who trained at Penn in both medicine (M.D., 1982) and business (M.B.A., 1987).[86]

"In a month, I knew Penn didn't know how to do it," concluded Ronald Barg, who brought his practice into the health system in February 1995.[87] However, for about two years, CCA liberally invested and supported the practices, and Barg's work did not suffer. "As time passed, we realized CCA wasn't able to run things efficiently and that most docs knew how to do things better."[87] By 1997, the happy days for practices like Barg's were ending. "My practice, which was making big dollars before joining Penn, began to lose money."[87] Although the new managed care contracts were paying significantly less for Barg's and his colleagues' services, he believes that the inefficiency of Penn's administration of the practices contributed importantly to the reduction in income. Furthermore, no longer running their own businesses removed an important stimulus for the physicians to practice efficiently.[87]

Despite the troubles with CCA, Barg agreed to enter the health system administration as regional medical director in 1998 and senior medical director the next year with responsibility for coordinating the teaching programs, quality assurance, physician contracting, and the work of the operations personnel. Barg continues to practice general internal medicine a half day per week at his old office in Bala Cynwyd.

The Medical Center Stumbles

Just before the losses started, Kelley had lost the services of Wilbur ("Bud") Pittinger, his longtime friend and colleague and chief operating officer for the health system. Pittinger's authoritative style had so annoyed some of the more influential clinical chairs that Kelley had to relieve him. Stung by this experience and convinced that he should not create a similar structure with a dominant chief operating officer for the health system, Kelley appointed four senior vice-presidents, each reporting directly to him: William Foley for the hospitals,

John Kepner for strategy and acquisitions, Gordon Williams for academic and clinical practices, and John Wynne for finances. Later, when Gordon Williams left, Martha Marsh joined in the same rank for the full-time (CPUP) and the primary care (CCA) practices and managed care.

Kelley was seen to be corporatizing the Penn academic medical center. "He brought in the new world of the CEO," the investigator and longtime Penn faculty member Britton Chance described the force that had descended on West Philadelphia from the Midwest in 1989.[55] "We'd become labeled as the most corporate health system in the country," added Mark Kelley.[48]

Kelley "wore a blue suit and a red tie and rode in a town car," remembers Jeffrey Otten, chief operating officer at HUP from 1991 to 1993.[88] "When he fired Bud [Pittinger], he did it quickly and changed the locks on the doors—all corporate-like." Kelley acknowledges that he wanted to emulate the style of management of a Fortune 500 company. He favored "industrialization" of the medical enterprise, with "guidelines, protocols, electronic medical records, service-friendly, improved efficiency, a call center with patient help lines, and Web-based communication. Do it GE-style, best quality, minimal errors" with better branding of the already famous Penn name.[2]

Others concluded that despite Kelley's aim of operating like a large commercial company, the health system did not really follow the approved corporate style. John Fry, Judith Rodin's executive vice-president, believed that Kelley "didn't have the depth of management to do it," that "full integration of the health system was never fully executed."[89] Wanting to offset the complaint that he had become inaccessible to the senior faculty and staff in the medical school, Kelley arranged that each department chair and institute and center director and several of the assistant deans report directly to him.[63] Accordingly, the total number of physicians and administrators directly reporting to Kelley exceeded fifty people,[16,63] an arrangement that the management professors in Penn's Wharton School would not have favored. Kelley was, thereby, functioning as his own chief operating officer as well as in his assigned role of CEO/dean.[63] This structure for the organization supported the observation of many that William Kelley was now running the medical enterprise at Penn as if he was still chairing a department of medicine as he did at Michigan.

Kelley responds to this criticism by observing that each of the twenty-eight department chairs and twelve institute directors expected to have a personal conduit to their dean. He tried to reduce the number of individual meetings by encouraging these leaders to take up their issues first with Dick Tannen, his

senior associate in the dean's office, a position that Kelley calls his "chief operating officer for the medical school."[61] Tannen would review the chairs' and directors' problems regularly with Kelley, but they could meet with the dean individually if they thought that necessary.

Thus, many people claimed the right to confront the dean/CEO with their problems directly. "Even though Bill's able to deal with many projects," says Tannen, "it became a virtual impossibility to be on top of our very complex financial troubles. He had gotten himself into an administrative position not suitable for sorting out such tough times."[63] The chairmen and center directors sensed this, as they were no longer able to see their extremely busy dean as often as they wished partly because he was so preoccupied with the problems of the health system.[7] Although functioning, in some respects, as surrogate dean after he arrived at Penn in 1995, Tannen had limited authority even though Kelley tended to micromanage less in the medical school than in the health system,[7] concerned, as he was, that his senior administrators were not working well together.[61] One of the senior executives decided that Stalinist Russia under Pittinger had been replaced with Yeltzen's Russia under Kelley.

After Bud Pittinger left, the office of executive director of HUP had been difficult to fill with a permanent resident and was repeatedly vacant. "There was so much churning in the management team," remembers former health system executive Gavin Kerr. "Doctors and staff lost confidence and trust in whom they were dealing with. The false starts cost time and money, which scared managers and froze them."[90]

This history of management turnover preceded Kelley's arrival in 1989. During the five years before his recruitment to Penn in 1990 as director of human resources for the medical center and then the health system, Dennis Colling remembers being told that, during the 1980s, twenty executives, including directors of HUP, finance, nursing, operations, and human resources, had left. "Welcome, you seem like a nice person, but you won't be here long," was the greeting he heard given to many a new administrative recruit.[91]

Contributing to these events was Kelley's dominating nature. During meetings with his staff, few would argue with him[69] because "it was so tiring,"[92] leading to isolation from his associates.[90] "His inner circle was 'yessing' him more than was helpful," observed one of his senior faculty members.[93] Although Kelley would eventually accept suggestions at variance with his plans, "you'd have to really push." When the four health system senior vice-presidents, each of whom reported directly to Kelley, saw him "going off on a tangent that

wouldn't work, they would sit there mute." Consequently, he usually worked individually with his staff, where, he felt, "issues could be discussed with more candor and worked to a productive resolution."[61]

In this unhealthy setting, the senior vice-presidents were seen "building their own kingdoms, spending like crazy and fighting with each other." Complicating decision making, Kelley would assign the same job to two people, which led to further conflict.[29,69] The system produced a large, expensive, and, in some cases, duplicative superstructure as each of the executives staffed up independently of the other. Without incentives to work together,[74] the team became divisive,[29] a conclusion with which Kelley ruefully agrees.[2]

Despite his passion to improve the medical school, for many years of his tenure and particularly toward the end, Kelley seemed preoccupied with the health system because, he explained, "That's where the problems were."[51] His impatience, which helped to improve Penn medicine so quickly, also tended to pressure his business associates into spending money rapidly and not debating issues.[92] "Bill was driven. He forced people to move fast," one of his administrators thought. "Some executives had unlimited budgets and grew haphazardly and too fast."[62]

Decision making could be surprisingly informal and unstructured. The last person in Kelley's office, whether a chair or an administrator, usually got what he wanted, several of his staff remembered.[90,94] "Management by sound bite, rather than by organized planning," Gavin Kerr, a member of the health system staff from 1995 to 2000, described the process.[90] "We called ourselves 'the place of 10,000 deals,' " said another executive. "The rift between finance and operations was tremendous."[94] In time, Kelley would come to realize that he should have appointed a single chief operating officer for the health services soon after Bud Pittinger left. However, he was assailed by the concern that, "given the intensely difficult marketplace, I couldn't afford to make a mistake and appoint the wrong person.[2] I had to find someone whom I knew could do the job, which I was finally able to do in early 1999."[51]

Edmond Notebaert, the longtime CEO of the Children's Hospital, saw Kelley "trying to run HUP, not what he was trained to do. Just because you can build an academic center doesn't mean you can run a hospital system or managed care." Notebaert believes that if you do not have the personal experience and knowledge to do something, "you must at least know if the people you've hired can do the job right."[95] Kelley came to accept some of these

criticisms. He appreciated that, although called a "genius," as one of his colleagues put it, at identifying academic talent, "I couldn't recognize administrative talent as well as Bud could. He could manage John Wynne [the health system chief financial officer] well; I couldn't." Others support this observation. Wynne was much admired for improving financial operations at HUP after Pittinger recruited him as chief financial officer in the early 1990s,[1] one of the leading clinical chairmen describing Wynne during his HUP days as "tough as nails, but we all respected him for what he did."[22] When transferred to the health system, however, Wynne had, Kelley came to believe, appointed himself the corporate chief operating officer without the title and made many deals as well as major financial commitments without Kelley's permission or knowledge.[2]

"We're Out of Control. We're Going Under."

As the first clues to the oncoming financial predicament became evident, Kelley did not seem to realize the implications of what was happening and held to his modus operandi. "The only way to get out of the losses is to grow out of them," he told colleagues.[48] "Tomorrow will fix things."[48] Kelley knew that income would grow principally through the physicians increasing their productivity while the administrative staff controlled the costs.[61] The fundamental problem with the improvement-through-growth thesis was that further growth meant more expenses rather than savings. The burgeoning income from their grants looked great, but it covered all the operating expenses of only a few of the most successful professors and did not pay for the investments made to bring them to Penn. Support and development of the research establishment, Kelley's love and pride, depended upon a river of money continuing to flow from hospital surpluses, which were now rapidly disappearing.

The new reality conflicted with fundamental features of Kelley's character. As admiring colleagues said:

— "Bill's about building, not remodeling."
— "Bill's a visionary, not a detail man."
— "He still believed to the end that he could grow out of it by getting bigger still. Bigger volumes in the hospital would support the research."

Kelley's enthusiasm for growth never wavered. In 2000, no longer the Penn CEO/dean, he said, "As in the corporate world, I wanted to budget 5 percent of the $2.2 billion budget for R&D. That's the way to get return on investment. If you're not of that mind-set, it won't happen. If it's not done, the next era suffers."[2]

The period of wealth, many thought, had made Penn's financial management lax. "We'd gotten fat and happy," is the way Will Ferniany puts it. "We'd spent because we were rich."[62] The health system had become overburdened with administrative personnel hired to market and administer the capitated managed care, which was not proving to be profitable. The money required to build the infrastructure had been grossly underestimated,[94] and, Kelley says, "we moved aggressively to reduce those costs when I realized that was the case."[61]

Becoming concerned about "Wynne's defensiveness with everyone," Kelley considered relieving him throughout the summer of 1998[60] and sought advice from senior university officials. They recommended keeping Wynne, telling Kelley, "he's a good financial guy, and the president, trustees, and rating agencies trust him."[2] So Wynne stayed, but Kelley told him that his "future depended on his not being so defensive and reactive,"[2] and assigned specific objectives for Wynne to meet over the next several months.[61]

Wynne had developed a painful chronic illness, and "was not thinking clearly," Kelley observed, "so no one could raise issues with him," producing "an unhealthy dynamic that I didn't know about."[2] Finally, in February 1999, Wynne requested a medical leave, which Kelley, with some relief, granted. On Valentine's Day, he appointed Robert Martin, then administering Clinical Care Associates, chief financial officer for the health system.[96] Kelley told Martin, "You just tell me whatever you discover." Martin proceeded to "uncover," in Kelley's words, "things that we should have known about."[61] By March, Kelley fully understood the extent of the financial problems that he and his colleagues were facing.[61]

Kelley concedes that he should have rejected the advice he was given not to replace Wynne during the previous summer, acknowledging "we lost seven months when we should have acted."[2] Wynne knew the state of the health system's finances, for he was heard to say, "we're out of control; we're going under," and that the system must take out $100 million per year for each of three years through a combination of more earnings and less expenses.[27]

Reversing the Losses

As soon as Kelley became fully aware of the extent of the current and projected losses in March 1999, the health system began to reduce costs. By June 30, the health system had eliminated about 600 of the 4800 positions at the hospital, including whole departments and many nurses.

Of the $198 million the system lost in 1999, approximately $80 million constituted end-of-the-year adjustments. The health system, which had been carrying questionable billings as collectable for months, finally wrote them off as lost.[81]* Employees who were being discharged required an unbudgeted $30 million in severance and related costs. After removing the one-time charges made during June, "the true loss was $78 million" during 1999, according to Kelley.[97] Since these adjustments were applied in the last month of the fiscal year, June 1999 would be seen as a particularly expensive month to the fiscally unsophisticated.

Optimist that he always is, Kelley saw the public focusing on the $198 million number, rather than the actual loss of $78 million, as advantageous both for him and, he believes, for the president, although for different reasons. Kelly was prepared to emphasize the number to "get people to buy in on what we had to do."[2] President Rodin liked the $198 million figure, Kelley believes, because she could use the immensity of it as further reason for firing him.[2] Clearly, the losses exacerbated the already strained relationship between the leader of the health system and the leader of the university.

As the size of the losses became evident to the administration and the trustees, board chairman Roy Vagelos decided to interpose an experienced business executive into the health system's management. In April 1999, he asked Russell Palmer, a university trustee who was the former dean of the Wharton School and, before then, senior officer of one of the large national accounting firms, to become directly involved. As Palmer became chairman of the executive committee of the health system board on July 1, health system executives projected losing as much as $250 million during the 2000 fiscal year without further aggressive reductions.[97] This assignment led to Palmer's devoting twenty to thirty hours per week to the health system during the next two

* The average number of days required to collect the bills was approaching 130 days, whereas the comparable number in similar hospitals was about 80 days.[94] Improvements in billing would decrease the days at HUP to 105 by a year later.[79]

years and meeting with Kelley as often as every other day.[14] Until Kelley left, Palmer's role in managing the health system became so basic that, in the view of trustee Richard Worley, "Bill's main role became that of dean. Russ effectively became the CEO."[72] Kelley describes Palmer's role as a "strong and effective nonexecutive chairman," but denies that his own role managing the health system had diminished to the extent Worley suggests.[97]

After more than four years without an effective number 2, Kelley had responded to pressure from Rodin,[98] Palmer,[14] and the trustees to re-create the position of chief operating officer. In June 1999, Kelley, now convinced he had the right person for the job, promoted Robert Martin, his chief financial officer for the preceding five months, to the job Pittinger had previously held.[2] Martin, described as focused and tenacious, driven toward objectives and unconcerned about politics or public opinion,[14] proceeded to establish a rational administrative structure for the corporate headquarters. Martin told the faculty that he was prepared to donate his heart for someone's transplant: "I'll do fine since I'm heartless anyway. The Hunter Group's a bunch of softies compared with me."[56] (The Hunter Group were the consultants the health system had engaged to help reduce costs.)[99] In selecting Robert Martin as his chief operating officer, Kelley recognized that "I had to pick someone who could deal with Judy."[2]

By the fall of 1999, guided by the recommendations of the consultants and an internal oversight committee of executives, chairs, and trustees and led by trustee Russell Palmer,[100] Kelley and Martin instituted a program that would further shrink the operating losses.[97] The Hunter Group's formula for reducing costs and returning the medical system to financial order prescribed closing programs and reducing overhead, which meant significantly reducing the number of employees.[99] "Go through every area and identify $300 million of annualized performance improvement opportunity," was Hunter's charge.[94] The change was painful. The Hunter report, which had advised cutting 20 percent across the board, "served the purpose of lighting a fire under the institution," observed Robert Martin. "We had to go through one of those near-death experiences to get buy-in from the chairs."[101]

Although some money would come from collecting income better, most of the savings would result from reducing expenses, especially personnel. Before Hunter started on September 1, 1999, Kelley and the executives had already eliminated 1100 positions. The consultants suggested that the health system should relieve another 1700.

Hunter uses "benchmarks," and advises its clients what similar, well-managed institutions need to staff different functions. These benchmarks for staffing are typically lower than those of the troubled institution that has retained the consultants. Most of the savings would come from applying the Hunter Group's recommendations from its cost-center review. The unit directors were invited to present their explanations why the consultants' advice should not apply, in whole or in part, to their groups. In some cases, the health system executives agreed and did not force the layoffs Hunter recommended.[94] Additional savings resulted from closing entire programs. In addition to the cost of the employees, the health system also saved on consultants, travel, and other expenses required by the programs.[101]

In addition to accumulating growing operating losses, the health system's total debt, $170 million in 1992,[102] had risen to more than $800 million by 2000.[94] The interest required annually to support the debt was approximately $50 million; depreciation and amortization approached $100 million per year.[102] The ratio of debt to assets had reached a level that prompted the rating agencies that evaluate the risk of lending money to lower the health system's and Penn's credit ratings. Now the health system would have to pay more interest on any additional long-term debt it wished to obtain and on its current variable-rate debt, which approximated one-third of the total debt of the health system.[102] Furthermore, the operating losses had seriously depleted the health system's cash reserves. From $793 million on June 30, 1997, unrestricted cash and board-designated funds had decreased to $358 million by March 2000.[102] A reserve of $300 million would allow the health system to operate for about seventy days if all income ceased, thereby providing a measure of the liquidity of the organization. Chief financial officer Peter DeAngelis and the more fiscally conservative trustees preferred that the cash reserve approximate $1 billion.[94]

While the dollars were flowing earlier in the decade, Kelley had accumulated a cadre of highly compensated administrators, a sore point with faculty, who saw them earning two to three times what most of the doctors and investigators were making. Keeping these officers was untenable when the health system was letting 20 percent of the employees go, and, in time, each of his senior vice-presidents would leave. John Kepner, who had helped develop the primary care practices and build affiliations with off-campus hospitals, returned to his law firm. Martha Marsh, who ran CPUP and CCA, left to become CEO of the teaching hospital for the University of California at Davis.

John Wynne, the chief financial officer, retired because of his illness and Kelley's increasing dissatisfaction with his handling of the financial problems that had developed.[60] Mark Kelley, the vice-dean for clinical affairs, realizing that the need for his assignment in developing programs for the health system "was dying and I'd run out of things to do," looked for a place to "bail out."[48] The job of chief of the medical service at the Penn-affiliated Philadelphia Veterans Administration Hospital had become available, and Mark Kelley took it in 1999. Tom Beeman, who directed the hospitals Penn owned, left in 1999, the last of the highly paid senior vice-presidents to go.[103,104]

Nevertheless, despite the many problems he faced, Kelley showed his inherent optimism. In December 1999, he said, "In every academic medical center that called in Hunter, the CEO lost his job. We're turning around the losses, and I'm going to survive."[2*] His colleagues were seeing the never-give-up Kelley in action. "Bill loves challenges," says Dr. James Stinnett, a senior psychiatrist and former chair of the HUP medical staff. "I think it was very hard for someone like Bill, who was so growth oriented, to retrench and cut back on things, but he did it."[105]

One of the largest units to close was one of Kelley's favorites, the health system's program in health and disease management, a heart-wrenching decision for him. This group, which developed best practice guidelines to help physicians in the Penn network care for their patients more effectively and economically,[106,107] cost about $5 million per year and included sixty people when fully staffed. The program, unfortunately for its survival, depended for its support largely on health system income and could develop only modest direct means of support by contracting with others to use its protocols.[2] Kelley realized that the plan, if successful, would decrease revenues in the health system as physicians, following the guidelines, sent patients less frequently to emergency departments, admitted them less often to the hospital, and shortened the amount of time those requiring admission spent in the hospital. The insurance companies, not Penn's health system, would benefit financially by the application of the principles being developed by the program in health and disease management. Although strongly favoring the work of the group because it would benefit patients, Kelley understood that the structure was "not a

* Clearly, Kelley's admiration for the Hunter Group's advice is limited. "The final report from Hunter had 350 recommendations, including closing some of the hospitals, Radnor, and the department of family practice." he said. "Much of this was supposed to be completed eight days before I received the report on January 1, 2000."[61]

good model for success given the misaligned incentives that exist in health care."[2] Consequently, when the deficits appeared, health and disease management was among the first programs to be shut down.

Some faculty members were surprised that Kelley supported health and disease management so strongly. "It was Bill's view of the future of medicine. He was very committed to it," one of his administrative colleagues said. "When I asked him, 'Shouldn't we see if disease management really works?' he gave me a lecture on how waiting could destroy the program."[62] Sanford Schwartz, who says that "research proving the value of such disease management groups is still lacking," believes that Kelley "undertook too many disease management programs at the start rather than concentrating on a few. Although Bill loved and supported it, the departments at HUP did not."[16]

A busy CPUP clinician, who had trained at Penn but had practiced at other local hospitals, suspected that Kelley's affection for this program reflected his lack of experience "in the real world." Although the program "sounds great among a group of educators," this doctor suggested, Kelley did not grasp what was really going on because "he was never in practice working with docs in the front line." Cardiologist Paul Rogers, then becoming an increasingly disgruntled CCA executive, said, "Disease management became a big sore spot. Few docs liked it although we were forced to work with it."[108*] The program did have strong public relations value, however. The university and health system glowed when the *New York Times* published an article on the subject that featured Penn's program.[107] A senior administrator saw the program as an example of Kelley's interest in gaining national respect—"Look at all the awards we're winning"—rather than emphasizing local projects.[79] Kelley, however, never lost confidence in the value of the unit. He would have built it up again when the money returned and if he were still in charge.[2]

Another casualty was the department that developed and managed the full-risk capitated contracts. It cost between $10 and $15 million per year for its sixty full-time equivalent employees and to pay for the losses the contracts produced. Since the health system had decided not to continue such contracts in the future, the office was gradually wound down.[94] Network development, useful during the growth phase but not needed during this consolidation period, was also shelved.[101]

* Kelley responds that "data generated anonymously from physicians in CCA indicated that 90 percent were satisfied or more than satisfied with the program. A few like Eisner and Rogers were strongly opposed."[2]

More money had to be saved, and saving money hurts. "There's lots of bleeding," says Gerald Jacobson, a Philadelphia health care consultant, because "Penn's done what hospitals in trouble do."[109] Accordingly, many of the faculty and staff complained how the reductions had harmed services and the spirit of the place. "Since the cuts," says Jim Stinnett, "morale has dropped, and the quality of patient care has dropped. Clinical slots are not being filled, and the number of support staff is down. In my office, two of the three psychiatrists doing consults in medical psychiatry left. Our secretary is gone, and I have to borrow one."[105]

Marjorie Bowman, the chair of the department of family medicine, agreed, observing that "the halls are dirtier, and patients have more trouble getting appointments. Sometimes it takes months. My office spends so much time arranging procedures—weeks for a scan, months for a sleep apnea study, a month to get a rheumatology consult for an acute full-blown case of RA [rheumatoid arthritis] even after talking to the attending."[110] Brian Strom, the general internist who chairs the department of biostatistics and epidemiology, observes, "No one answers the phones. I get messages a month later."[111] Even before the cuts, Kelley had tried to do something about the phones. He had ordered that, throughout the health system, someone must answer every call after no more than two rings. He even arranged to monitor the process and would confront doctors and administrators whose departments could not follow the rule. The results of what came to be called "the telephone crusade" were disappointing,[34] as were most of the other efforts to improve patient satisfaction, Kelley admits.[2]

Despite these complaints, many inevitable in view of the reductions in service that the layoffs produced, the change constituted what Robert Martin called "the largest and most successful turnaround in academic medicine."[101] In the fiscal year ending June 30, 2000, which was four-and-a-half months after Kelley was discharged, the health system lost $30 million on operations, sizeable but significantly less than the $198 million loss during the previous year[112] and much less than the $250 million projected as the fiscal year began on July 1, 1999.[14]

Looking back, Martin sees the climate in Kelley's initial years as not calculated to producing a financially tight operation. "The incentives that Bill built into the system were primarily academic rather than clinical. His investigators knew they must develop successful research programs well supported by the NIH and other sources. Although the clinical faculty understood they

had to bring in enough money to support their salaries, they had little incentive to reduce expenses."[101] Martin sees as one of his most important challenges convincing the clinical leaders to accept responsibility for regulating how their clinicians consume resources. "I must develop incentives to accomplish this."[101]

Separating the Health System from the University: The Blue Ribbon Committee

Despite the accomplishments of the medical school, the financial losses of the health system, which were becoming known by the winter of 1999, led university president Judith Rodin and leading members of her board of trustees to question whether Penn's owning the health system was such a good idea. To investigate the decoupling option, the university created what became known as the "blue ribbon committee." Its mission, in the words of Roy Vagelos who, as chair of the university trustees, had convinced Russell Palmer to lead the group, was "to look at the future of the health system and the medical school."[75] Under the current arrangement, the trustees of the University of Pennsylvania delegated supervision of the University of Pennsylvania Health System to its health system trustee board consisting of university trustees and other appointees.[113] Kelley reported formally to this group,[113] and functionally to its fifteen-member executive committee, now led by Palmer, and also, although not by his choice,[2] to the president of the university.

Several members of the university board had, in provost Robert Barchi's words, "become very focused on setting up a firewall between the health system and the university."[32*] The administration feared that the courts could "pierce the veil" separating the university from the health system and hold the university fiscally responsible for the health system's present and future losses.[52] By separating, the university hoped to minimize the financial risk without relinquishing control of the health system.[44,115]

Independence for the health system should also allow its managers to maneuver more rapidly without the restrictions of the university bureaucracy.[32,111] "The faculty may want a combined structure as they have now," said Palmer,

* The university had attempted to protect itself financially from health system losses about ten years previously. Former chairman of the university board Paul Miller, a Penn alumnus who had prospered in a financial firm he co-founded, chaired an ad hoc committee charged to "shield the university from hospital losses."[114] The group developed a master trust indenture that protected the university against the effects of HUP's defaulting on its debt.[114]

"but to make money, you have to compete against the local marketplace, not against Hopkins. The health care market is moving at lightning speed, the academic side moves glacially."[14]

Complete separation, however, the lawyers said, not just a change in the reporting structure, would be necessary to protect the university from the financial repercussions of health system losses.[35,116] Would the medical school and the university really want to resign their rights to exercise any authority over the teaching hospitals?

Throughout the deliberations, Kelley continually opposed splitting the health system from the medical school, but, "I had been instructed, at the time, not to discuss the committee's deliberations with the faculty,"[61] even though he suggested on several occasions that he do so.[97] What Kelley favored was creating a separate corporation within the university for the entire University of Pennsylvania Health System, including the school of medicine. This would "take Judy out of operations," a development he much favored.[2] Palmer called the idea "a nonstarter, as Judy would never accept it."[2] So Kelley's effort to insulate the health system administration from a president he saw as inappropriately interfering and an impediment to progress failed.

After consulting with leaders at other renowned academic medical centers, the committee endorsed, in a vote with only Kelley in opposition, the concept of spinning off what chairman Russell Palmer calls "the commercial portion of the health system," consisting of the hospitals and CCA into a separate not-for-profit corporation.[14] The medical school and CPUP would remain within the university[89] under the jurisdiction of the dean. Some of the directors of the new corporation would be nominated by Penn, some by the CEO, and others would come from the outside. The committee recognized that the firewall they desired to construct would be "porous at the beginning," but hoped that in time the university would gain the protection it desired.[14,72,89]

The blue ribbon committee was unable, however, to settle several fundamental features of the plan. To gain financial protection, would the university really want to, in essence, relinquish control of the health system? Who would settle conflicts if the board of the university and the board of the health system differed?[89] Several features of the split were never defined, including "a bridging mechanism with the university"[14] and the structure of the firewall.[117]

Finally, in the future, what if the new corporation decided to sell HUP or other parts of the health system, totally separating them from Penn? Such an action if carried out in the near future might prove quite a challenge.[111] Here

was a large medical enterprise struggling in a city without a public hospital, in a state with notoriously poor payment for the care of indigent patients, and with the number of poorly or uninsured patients admitted to HUP and Presbyterian growing.[111]

As the committee members deliberated, many members of the medical community speculated that the president and trustees had several unspoken reasons for separating the health system from the university. Among the more persistent rumors were that the trustees were trying to protect themselves from the fate that had befallen the AHERF trustees, several of whom had been accused of criminal activity,[111] and that the whole effort was fundamentally a maneuver to get rid of Kelley. Separate governance of the health system and medical school would force Kelley to select, if he were given the choice, which part he would direct. Unwilling to make such a choice, would he, in effect, be forced to leave the university?

Another scenario suggested that Rodin would relieve Kelley as CEO and try to retain him as dean of the medical school, a role in which he was acknowledged to have been highly successful. If he were willing to remain as dean, he could help reduce disharmony among the chairs and faculty at the change in the leadership of the health system.[72*] Whichever course Rodin chose, changing Kelley's role would support the widely held impression that the relationship between the CEO/dean and his boss had become impossible to sustain. "The faculty's idea about Bill's being a part of the plan was wrong," said Palmer.[14] Provost Barchi agreed, although he acknowledged that university leaders did discuss such an eventuality privately.[32]

By December 1999, the clinical chairs learned that the blue ribbon committee favored breaking up the University of Pennsylvania Health System.[44] Some of them asked to talk with Palmer, who met with them—Kelley was not present—and presented the proposal that the committee and its consultants favored separating the hospitals and CCA from the university. Faculty members complained that the committee had decided what to do without consulting them, that this meeting was more an announcement than a discussion.

The basic science chairs were advised of the plans by John Fry, the university's executive vice-president, at a 7:30 morning meeting on January 5, 2000.[44] A participant sensed "very bad blood" at that meeting. "We were all sufficiently

* Such a potential solution recalled the events of 1973, when the direction of Penn's hospitals was taken away from Alfred Gellhorn, and the president, at the time, tried to convince him to stay at Penn as dean.

irritated to ask the university people to leave, and then we decided to meet with the clinical chairs," remembers Priscilla Schaffer from the department of microbiology.[44] The combined group commissioned John Glick, the director of the cancer center, David Longnecker, chair of anesthesia and of CPUP, and Schaffer to write a letter to Rodin, Barchi, and the chairs of the university and health system boards of trustees explaining why the chairs in the medical school opposed the change. They complained that the faculty had not been consulted—the chairs had heard that the university planned to file papers with the court to split the health system by July 1, 2000[111]—and stressed that "the school is the faculty."[44] Each of the chairs signed the document.

The chairs now spread the news,[118] producing almost universal opposition to the change among the faculty. The tight linkage of HUP and the medical school had greatly assisted the development of Penn's superb research enterprise. The turnaround of the losses had surely demonstrated that the combined structure could work.[115] The faculty's thinking was conveyed privately to the university administration.

On the evening of February 1, more than 600 members of the faculty, approximately half the active faculty, an extraordinarily large number, met in the school's largest auditorium, where some had to stand. Provost Robert Barchi, himself a former chair and center director in the medical school, described the proposal the trustees' committee was considering. The chair of the medical school faculty senate called for a vote, and those assembled chose unanimously to keep the current structure melding the health system with the medical school.

Barchi then announced that the committee's proposal would not be instituted at that time.[119] Kelley, whom colleagues observed had lost weight and did not look well, sat quietly in the front row and said nothing, clearly relishing the vote of support for what he had accomplished with the combined structure. As a member of the blue ribbon committee, Kelley had agreed not to speak at the meeting.[2] Colleagues, empowered by the events of the evening, wondered whether the president would have fired Kelley then and there had he stood up, acknowledged the applause, and spoken. To deflect any conflict their presence might cause, neither Palmer nor Rodin was invited to attend.

Theories about the events raced through the medical center:

— "Its secretiveness, which led to all sorts of wild rumors, killed it."
— "Most of the faculty did not know the leaders were in revolt."

— "The code word for the result was 'nonparticipation.' "
— "You could smell the rubber burning as Bob [Barchi] backpedaled."

Actually, explains Barchi, the committee was "heading away from a split," not being able to develop a plan that would fully protect the university from the financial problems of the health system without losing control over it.[32]* Rodin adds, "The discussion was so contrived by the background noise, it is really difficult to know [how the issue would have eventually been decided.] We [the university trustees] never really voted, and there is no real sense of what would have sold to the trustees even then."[98]

Kelley, Palmer, James Riepe, a university trustee and later chair of the board, and Vagelos remember the events differently, that, until the faculty revolt, all the committee members except Kelley favored separating the hospitals from the medical school.[2,14,75,121] Several participants wondered whether Rodin would really be willing to relinquish control of HUP which, despite its problems, added luster to the university she led. In any event, the faculty's strong negative reaction caused the university administration to table any further action on splitting the medical school from the health system.[89] As trustee Robert Fox observed, "Judy didn't have a choice because of the faculty."[77]

Those members of the faculty who "didn't see this primarily as 'a Bill thing' " opposed the change because, they believed, a combined medical school and health system was a better way to operate the medical enterprise.[111] Several saw that the health of the combined structure depended upon aligning the incentives and efforts of the doctors and the health system, and, that if separation occurred, they would be constantly fighting.[115] Nick Bryan, the radiology chair, said, "I was vocal that this was not the direction to go." Bryan had seen in Houston how "the separate model at Methodist [Hospital]/Baylor fostered individually strong programs but inhibited development of an academic, research-oriented medical school." He did not relish going through this at Penn, having most recently worked at Hopkins, where the separate governmental model had been converted into a functional single model under a dean/CEO.[35]† One health system executive reflected the opinion of many in the school in saying, "The unified approach with one person as the CEO and

* The reverse occurred in New York City, when the trustees of the Presbyterian Hospital offered to sell the hospital to the Columbia University College of Physicians and Surgeons, its academic partner, in 1995. The dean agreed, but the Columbia University trustees demurred, uncertain how the university's assets could be protected if the hospital continued to lose money.[120]

† See chapters 6 and 7.

dean enables you to put the academic mission and process first,"[18] which was certainly Kelley's priority.

Because the medical center had been created fifteen years earlier, most of the faculty did not remember a time when the medical school and hospital were separately governed, and some members wondered how much the old saying "better the devil you know" described how many of their colleagues felt. Nevertheless, members of the senior faculty saw the meeting as a skirmish that "drove Rodin and Barchi underground."[36] They feared that the administration had simply tabled the dual leadership concept. "We knew it would only be temporary," said one.[44] There was truth to this rumor. Trustee, later chair of the board, James Riepe explained, "We deferred it till we'd gotten through the financial turnaround."[121] The trustees also had not decided how the separate aims of the health system and the medical school could be best resolved and managed.[121] Some faculty members worried that "the faculty may have hurt themselves by taking such a rigid tack with the blue ribbon committee."[84]

Russell Palmer and other leading trustees were listening to the faculty's opposition to his committee's principal recommendation. He now realized that the faculty "would hate affiliating with a for-profit." From his experience, however, he knew that "the alternative of staying the same is no alternative. I can't accept the 'let's pray' approach."[14]

It would probably surprise many in the medical faculty to know that Rodin had consistently favored an integrated organization,[98] "if the talent pool allows," she says in referring to the shortage of academic executives qualified to lead such complicated structures.[98] She sees the advice of the blue ribbon committee more in the nature of an effort to "solve a short-term problem rather than provide a long-term solution" in the management of the medical enterprise and acknowledges, "We're one of the failures, but the trouble was Bill, not our structure."[98] This lack of support from his boss, which Kelley finds unique in the course of his illustrious career, "made a tough job immensely more difficult."[61]

The Wilson Problem

One of Kelley's favorite enterprises at Penn was the Institute for Human Gene Therapy. He had long believed that manipulation of the human genome offered one of medicine's greatest opportunities and, supported by the rec-

ommendations of the Molinoff committee,[2] had allocated large amounts of money and laboratory space to the project, too much of both, according to several critics. "He lost his perspective since this was his baby, his field," one senior faculty member complained.

To lead the effort, Kelley recruited James Wilson, one of his former Michigan colleagues, who arrived on the Penn campus in March 1993 as the director of the institute and chair of a new basic science department of molecular and cellular engineering.[122] Wilson's unit would conduct basic investigations and, at the appropriate time, perform clinical trials of gene therapy.

The death, on September 17, 1999,[123] of a patient in Wilson's unit who was given an experimental genetic preparation focused unwelcome national attention on the university and on the system of protecting human research subjects in general[124] and helped to bring about Kelley's departure, many believed. In response to the death, the Food and Drug Administration (FDA) temporarily shut down all human gene therapy experiments at Penn. Evidence had emerged, the FDA concluded, that the patient who died was not eligible for the study and that the scientists had failed to report serious side effects in other patients.[125] Wilson and Penn officials vigorously refuted the facts and relevance of these allegations.[126] By May 2000, however, after receiving a report from an expert external committee, President Rodin ordered Wilson's work restricted to nonclinical projects.[127] By now, Kelley, the leading supporter of Wilson's research at the university, was gone, and the work of his pet project was being severely curtailed.

Complicating the issue further was Wilson's relationship to a for-profit company[128] that funded nearly a quarter of his work and would benefit from discoveries that were commercially applicable. Wilson and the university owned stock in the company, and Wilson held separate patents that could produce sizeable financial awards if effective therapy based on their discoveries became available.[128] To accommodate these arrangements, the university, with Rodin's active participation, according to Kelley,[2] had managed as carefully as possible through its conflict-of-interest guidelines to secure Wilson's continued association with Penn.[128]

A year after his death, the family of the patient who had died filed suit against the university, Kelley, Wilson, and others which alleged that the consent form that the subject signed understated the risks and that the experiment was "fraught with conflicts of interest . . . not sufficiently explained" to the patient.[129,130] The suit was quickly settled[131] for what the *Inquirer* called "a

substantial sum."[132] Kelley had been dismissed from the suit and was not part of the settlement.[2] Emphasizing the importance of the affair, Britton Chance, Penn's distinguished investigator for whom one of Kelley's new research buildings had been named, said, "The Wilson problem is one of the worst things to have happened to the university in its history."[55]*

Kelley versus Rodin versus Kelley

"You're either with him or against him, the university included," says Stanley Goldfarb from the department of medicine. In this opinion, Goldfarb expressed the sense of many members of the medical school faculty that Kelley saw the university and its president, Judith Rodin, as adversaries to the medical school.[134]

Members of the faculty and trustees praise the president of the University of Pennsylvania since 1994 as talented, bright, personable, attractive, articulate, charismatic, a quick thinker, analytical, and engaging. "She thinks like a social psychologist, in cognitive terms," says Larry Gross, a professor in the Annenberg School of Communication and recent chair of the university faculty senate. "She believes in evidence and data, that things operate according to certain principles. She doesn't brook foolishness or mistakes."[135] Her close associate, university executive vice-president John Fry says, "She reads a room magnificently. Her training in psychology has been an enormous advantage to her and to Penn."[89]

According to many observers, Rodin's style of leadership emphasized the corporate or executive model[117] and was seen to be less academic than that of her predecessors.[20] However, although some faculty criticized her for focusing more on business and buildings than on scholastic programs, this style appealed to many trustees.[20] Claire Fagin, her immediate predecessor, said, "The trustees were mad about her and what they believed she could and would accomplish for Penn. She became very popular with both trustees and alumni and won support in the wider Philadelphia community as well."[20]

Features of her character, however, such as determined, controlling, a strong-willed leader with a vision where Penn should go, might be expected to bring her into conflict with someone like William Kelley.[136] One can understand, therefore, why their relationship was often described as "oil and water."[137] "Bill and Judy are more alike than they see each other," observed a

* Wilson would "step down," as the university announced the action, from the directorship of the human gene therapy institute at the end of the 2002 academic year.[133]

faculty member who knows both of them.[138] In the view of Donald Langenberg, chancellor of the University System of Maryland and a Penn trustee throughout the 1990s, "she is just as ambitious as Bill. She wants to take Penn from the comfortable second tier right up to the top."[136]

Unlike Kelley, however, Rodin is a Penn veteran, having received her bachelor's degree in psychology from the university in 1966. Her father, Morris Seitz, an accountant and insurance agent, was a Wharton graduate. Born in Southwest Philadelphia,[139] not far from where Penn is located, Rodin attended the Philadelphia High School for Girls ("Girls High"), where the students are competitively selected for admission, and graduated 3rd of 147 in her class in January 1962.[140] While studying at Penn, where she met her first husband, Bruce Rodin, she participated, as president of the Women's Student Government, in merging the men's and women's organizations. Highly competent intellectually—Rodin was elected to Phi Beta Kappa at Penn—she was described by one of her former teachers as "an unusual and enormously promising student."[140]

Receiving her Ph.D. in psychology from Columbia University in 1970, Rodin taught at New York University for two years. During 1971, she was also a National Science Foundation postdoctoral fellow at the University of California, Irvine. Then, in 1972, Rodin became assistant professor of psychology at Yale, where she was promoted to full professor with tenure by 1979 and to an endowed chair in 1984. In her research, Rodin studied obesity, women's body image, stress, aging, smoking, women's changing work roles, and the relationship between psychological stress and self-destruction.[141] She is the author, coauthor, or editor of ten books and more than 200 research reports and chapters and has been the editor of two, and on the editorial board of thirteen, journals in her field. Several highly competitive funding organizations, including the National Science Foundation, the National Institutes of Health, the MacArthur Foundation, and the John Simon Guggenheim Foundation, have supported her research.

Beginning in 1989, Rodin filled a series of senior administrative posts at Yale which, in the course of five years, took her from department chair to dean of the graduate school of arts and sciences to provost, the university's senior academic officer, and candidate for the Yale presidency.[142*] In April 1994,

* A faculty member, informed about the Yale selection process, observed that "the college is the jewel in the crown at Yale, and Judy didn't have a Yale degree." He commented further that the president at Yale tended to come from the humanities, which worked to Rodin's detriment despite her positions as dean of the graduate school and provost there. "While Yale was not ready for a woman as

just before beginning her new job at Penn, Rodin married Paul Verkuil, dean of the Cardozo Law School in New York City and the former president of the College of William and Mary.* Her son, Alex, is an undergraduate at Duke University.

As president, Rodin wanted to raise Penn's standing among leading universities, in part, by improving the surrounding community to make Penn a more attractive place for students to attend and faculty to work.[143-145] For Rodin to accomplish her goals, she needed some of the health system's surpluses. When they disappeared, her plans for the university stalled, and, as one administrator suspected, "she lost faith in Kelley. However," he adds, "she also failed to figure out how to manage him and was just as mean to Bill as he was to her. John Fry and I would roll our eyes when Bill and Judy took off after each other."[29]

Rodin draws her share of criticism from south of Spruce Street, first of all from Kelley. "Judy never accepts blame because she never accepts a decision," he says. Although she and the health system board approved the purchase of Presbyterian Hospital, when the losses appeared, she said, according to Kelley, "You made a terrible mistake. It's a disaster," and implied Kelley was at fault.[2] Rodin believes the Presbyterian purchase "very smart," but faults how the health system dealt with the doctors there.[98] "It's incredibly hard to blend the culture of an academic medical center and a community hospital," she says. "The docs [who work at these hospitals] choose different ways of life."[98]

Some in the health system saw Rodin as "not skilled in health care management but wanting to control," while others, aware of her health care background, wondered why Kelley did not "work with her to make it work."[74] One of the senior trustees, a Kelley partisan, felt that Penn would have benefited if "Judy could have worked it out rather than continuously battling, so that Bill couldn't turn to her."

In 1999, Rodin had chosen Robert Barchi,† a neurologist and professor in the medical school, as provost,[146] the last job she had held at Yale. Was Barchi's appointment "to help her handle Kelley," a skill that some trustees hoped she

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president, Penn with several strong woman deans was. Moreover, Judy was a Penn graduate and a native of Philadelphia—a natural cultural fit."

* Verkuil thereby led one of the few colleges or universities older than Penn. William and Mary, in Wiilliamsburg, Virginia, was founded in 1693, fifty-seven years after Harvard.

† Robert L. Barchi: B.Sc., M.S., Georgetown (1968); Ph.D. (1972), M.D. (1973), Penn; neurology intern and resident (1973–1975), HUP; assistant professor (appointed 1975) to professor (appointed 1981) of neurology and of biochemistry and biophysics, chairman, department of neuroscience (1992-1999) and neurology (1995–1999), provost and chief academic officer (appointed 1999), Penn.

would manifest when she was hired as president?[91] Barchi was seen as one of the few medical school faculty members "who could stand up to Kelley."[147]* Although, organizationally, the president should have turned first to her CEO/dean for leadership and decisions about the medical center, that avenue became obstructed by the impasse that was developing between the two. Faculty members[56] and health system trustees[81] knew that Rodin and Kelley were fighting, "pulling in opposite directions,"[56,148,149] although they were courteous, always civil to each other at board meetings.[77,117] "I worked at it. So did Judy," says Kelley. "We put on a good front."[2]

Commenting on the failure of Kelley and Rodin to "attain an academic partnership," Charles Emerson, chair of the department of cell and developmental biology, the successor to the department of anatomy, said, "It's a dance. Both had responsibilities. At the beginning both leaders seemed very close,"[38] and, for as long as they worked together, their public posture was "always professional."[74] Emerson, however, remembers the university's efforts to institute a new financial management system. "It wasn't appropriate for the school of medicine; their computers couldn't deal with our data and created havoc at the grass roots, affecting the research activities of individual labs. This seemed the first crack in the 'one university' thing."[38]†

Why didn't Judith Rodin relieve William Kelley by July 1999 when the immense losses of the previous year were revealed, rather than seven months later? She wanted to, but was unable to do so.[98] In May 1999, "I told the chairs of the university and health system boards of trustees that I wanted to fire Bill," Rodin says.[98] The president had become deeply concerned about the effects of the health system losses on the university's financial security. Since Penn owns its university hospital, uniquely in the Ivy League, losses "go straight to Rodin's bottom line," as one of the former HUP chief financial officers explained.[150] Trying to bring more discipline to Kelley's operation, she pressed him for detailed data. This only led to further conflict between them. Several observers commented that Kelley was able to duck, for many months, losses that, one said, "would have gotten him thrown out in a for-profit business."

To gain the authority to relieve him, Rodin needed the support of the board,

* Kelley valued Barchi's talents. He had named him director of an institute and chairman of the department of neurology and had successfully countered the efforts of other medical schools to recruit him to senior positions.[2]

† "One university" was the slogan the university used as a basis for consolidating functions in the different schools and departments.[38]

and this required that some of the Kelley advocates depart. The terms of Roy Vagelos, a strong Kelley supporter, on the university and health system boards were ending. Rodin replaced health system board chair Susan Catherwood, another supporter of Kelley who, in her view, "could do no wrong,"[77] with Russell Palmer.[138*] Riepe and Palmer, both of whom had only recently been appointed chairs, Riepe of the university trustees and Palmer of the executive committee of the health system board, asked her to wait until they could look further into the situation and try to fix the problems. They feared that the faculty so admired Kelley that his discharge would prompt a rapid departure of some of the leading professors.[98]

Despite these potential consequences of a change in the leadership, Rodin saw relieving Kelley as essential, that her CEO would be unable to downsize. "Bill's a builder, not a retrencher," was a theme common in descriptions of Kelley at the time. Rodin saw the issue even more emphatically. Kelley, she said, "fought the reductions to his last day."[98]

Several of the trustees agreed that Kelley could not undo what he had created and did not have the will to get it done.[72,77] Kelley refutes this analysis. "At the time I was fired, we were projecting that, when the 2000 fiscal year ended, we would meet our very aggressive'break even' budget," Kelley explains. "Judy had just become aware of that projection, and, I believe, that played a role in her timing to fire me before that projection became widely known."[2] Palmer supports Kelley in this dispute. "Hunter told me we're not being stonewalled by Bill."[14]

Thus Kelley remained in his job into the winter of 2000, and, with Palmer and Martin, instituted the actions necessary to reverse the losses. The timing of his ouster, several faculty members suspected, was driven more by immediate events and political opportunities, and that, as one said, "the stiletto was Wilson." Barchi, however, who was privy to the decision making in College Hall, disagrees. "Kelley was keeping out of the Wilson business, which was much less important in his firing than people say."[32]

Kelley clearly did not enjoy working with his boss, and, despite what others may have thought, never had almost from the time of her appointment

* Kelley supporters refer to Catherwood along with trustees Myles Tanenbaum and Raymond Welsh as " 'health system junkees.' They couldn't get enough of us, and we couldn't get enough of them." Welsh, senior vice-president at Paine Webber, led a highly successful campaign to raise endowment for the medical enterprise.[138]

when the health system was flush with money.[2] "A highly regarded university trustee," according to Kelley, phoned him with the warning that, of all the senior executives then at Penn, Rodin's appointment put him "at the highest risk."[2]

Rodin, in contrast, says that "Bill was one of the reasons I came here."[98] She knew of his accomplishments, and the two shared membership in the Institute of Medicine. Unlike what many of her critics claim, Rodin insists, " I like working with extremely strong people." It was clear to all, however, that Rodin did not relish working with Kelley—"I was the only one who fought him," she acknowledges[98]—and, almost from the beginning of her presidency, many thought, "wanted him out." University and health system trustee Raymond Welsh observed, "Judy has confidence in people and can delegate, but she has a bad penchant to manage many decisions and wants her mark on everything."[81] Such a nature in his boss was difficult for Kelley, "who doesn't like being second-guessed,"[81] to accept.

Rodin, with several of her colleagues from the university, started regularly attending meetings of the eight-member executive committee of the health system board that Hackney and Fagan had rarely attended.[151,152]* This active participation by university officials in affairs south of Spruce Street much irritated Kelley.[2] "She wanted to run the medical center," he claimed, "unlike Sheldon Hackney and Claire Fagin."[2]†

When an appointment with Rodin was coming, Kelley would tell his staff with a long face, "I have to go to Judy's office."‡ This made them anxious about what would happen.[92] "I can see how Judy and Bill would clash," said Peter Traber, who would succeed Kelley. "However, the $2 billion thing hanging off the university [the approximate annual budget of the Penn medical establishment] was bigger than the Bill–Judy thing," he believed.[155] Rodin agrees.[98]

* Rodin, like Fagan and Hackney before her, had every right to attend these meetings since the health system bylaws, according to John Fry, "expressly provide for the president to serve as a member of the health system executive committee."[153]

† Claire Fagin, dean of the nursing school, was interim president of the university from July 1, 1993, to June 30, 1994,[154] between the terms of Sheldon Hackney and Judith Rodin. "Bill was in shock," Fagin jokes, "that he would have to report to a nurse. We got along great."[20]

‡ Kelley found Rodin's style "very irritating. She would insist on a complete agenda from me for every meeting we had together and being notified of anyone I was going to bring to it. On the other hand, when she called a meeting, even an urgent or emergency meeting, she would refuse to provide an agenda. Finally, you could count on most of her meetings starting thirty or more minutes late."[61]

Changing the Leadership

On Tuesday, February 15, 2000, the day before William Kelly walked across Spruce Street to be relieved of his job,[156] Peter Traber, chair of the department of medicine, took a call from the president's office. Would Dr. Traber please meet with Dr. Rodin at 5:00 P.M.? "I went to her office," Traber remembers. "She told me she was going to relieve Bill and wanted me to replace him. I would be interim CEO and interim dean. Judy wanted David Hunter to come back in as consultant. I asked to think about it overnight."[155] The decision was not that difficult for Traber to make. "I had a good feeling about the place, the teaching, the research, the people. To save the place, it ought to be someone who understood the place." Traber had been at Penn for eight years. "I thought I could do it."[155]

With Kelley's successor in place, Rodin sacked the CEO/dean the next day. She would let him retain the title of executive vice-president of the university, but Kelley saw this as "a joke, a title without a portfolio" that might interfere with his contractual rights.[2] Kelley made it clear that the decision was not his. "I am disappointed not to be able to see my long-term plans to full implementation," he wrote his colleagues. "But nonetheless, we accomplished a great deal together."[157]

Rodin made the change in her capacity as Kelley's boss with full approval, she says, from *her* bosses, the trustees of the University of Pennsylvania.[158] However, Rodin discussed in advance her reasons for discharging the director of what was, by far, the largest enterprise in her university with no public members of the health system executive committee except Palmer,[14,60,72,75,77,81,117] leading Kelley to claim that Rodin did not obtain the approval of most of the trustees before relieving him.[97] Board chair James Riepe acknowledges that "they were justified in complaining that they did not know [that Kelley was to be fired]. We could have handled it better." Riepe believes, however, that most of the leading trustees knew, and understood why, Kelley's days as CEO/dean were numbered.[121]

"Judy had the right to fire him but should have told the executive committee and taken questions," said Richard Worley.[72] "If trustees aren't consulted on important decisions, how do you get good people to take trustees' jobs?"[72] In the experience of attorney John Harkins, a member of the health system board, the CEO of a for-profit business would surely review with his board why he wanted to fire a senior executive of Kelley's standing in advance of doing so.

"She was assuming a risk" in doing so the way she did, said Harkins, with the approval of only the board chair.[117] Trustee Raymond Welsh said that explaining to the board before carrying out a decision of such importance is "the way it's done in the corporate world where I work." When asked whether this practice should also apply at Penn, Welsh, a university alumnus, trustee, and member of the health system executive committee, responded, "The university should be no different."[81]

As he became more intimately involved in health system affairs during the summer and fall of 1999, Palmer concluded that Kelley should not be fired and told Rodin so.[14] "We had an absolute roaring inferno, the most difficult situation I have ever seen. Do you know what turmoil his firing would cause? Forget about the past," he advised. "Only fire him if he isn't doing what's needed," and Palmer saw Kelley fixing the financial problems.[14] Rodin concluded that Kelley was "gaming Russ," obstructing changes, and manipulating the numbers.[152] Kelley adamantly objects, in the strongest terms, to these accusations.[97]

Other trustees felt as Palmer did. Ray Welsh, for example, believed that Kelley had the confidence of the department chairs and could convince them to swallow the unpleasant medicine that was required.[81] Robert Fox, the leader of a leveraged buyout and venture capital firm, an alumnus, university trustee, and member of the health system executive committee, feared, at the time, that Kelley's discharge would create a vacuum and that many leading doctors would leave.[77] Of seven outside members of the executive committee of the health system trustee board asked, none favored firing Kelley when he was relieved.[14,60,72,75,77,81,117] Praise from other trustees for what Kelley and his colleagues had wrought supported Rodin's long-held belief that most of the health system board members were "in Bill's pocket."[98] Kelley strongly objects to this characterization of his trustee colleagues. "These men and women made incredible sacrifices to help me and our management team through this very difficult time," he says.[61]

Not only was Kelley under pressure. From October to December, Rodin had been forced to endure "hours of consultation with my bosses, the trustees. It was a painful time," as she recalls. "Many were very critical of me for not acting on Bill. My role was to make sure that Penn survived in a time of great stress. The trustees expected this of me."[152] Firing Kelley pleased some trustees and distressed others. Palmer offered to resign from the board "because she fired him against my advice,"[14] but Rodin convinced him not to leave.

Kelley was prepared for what happened. One week before he was fired,

Riepe told Kelley, " 'We've basically totally lost confidence in you.' So I said to him, 'If Judy wants me out, why doesn't she fire me?' "[2] His annoyance with Rodin had continuously grown. "Judy got the Hunter Group to claim that my explanations of what went wrong were myths," he remembers. "The high level of indigent care was a myth. The money going to the university from the health system was a myth. She was putting me in an impossible situation and was doing all she could to discredit me. It became a full-time job just fighting her allegations."[2]

Kelley was particularly angered that the president had not publicly recognized that *U.S. News & World Report* had listed Penn as the 3rd best medical school after Harvard and Johns Hopkins—the school stood 10th when the Kelley years began—or concede that Kelley was successfully reversing the health system's losses. "She was losing her best reason for firing me, but she still had Jim Wilson's problems to blame me for."[2]

Rodin and the university administration strongly contested Kelley's claim that the financial turnaround was proceeding satisfactorily and that, therefore, her principal reason for firing him was evaporating. "Things on a cash basis still looked bad" in the winter of 1999. "Bill was claiming victory too soon. He wasn't doing it fast enough."[159] Rodin continued to believe that Kelley "wasn't mentally prepared to pull it apart."[159] From Kelley's perspective, these comments support his view of the reasons for the timing of his firing. "Indeed, in July of that year," Kelley said, "about four months later, Judy was quoted as praising the health system leadership team for achieving this major turnaround and dramatically reducing the operating deficit, essentially as we had projected in February."[97]

Kelley had let it be known that "when the time comes, I'd go quietly so long as the university honors my contract." As for making a fuss, he adds, "There was no point having a bloody warfare. No one would benefit, and the university would be hurt."[2] Kelley also wanted to protect his contract, which might be jeopardized if he went public with his complaints.* Kelley's employment arrangement as executive vice-president of the university and CEO of the health system had been due for renewal in 1996, not long after Rodin became president. At the time, before the losses appeared, Kelley's accomplishments at Penn made him a very attractive candidate for other top jobs, giving him and his

* The campus newspaper, *The Daily Pennsylvanian,* reported in 2001 that Kelley's [CEO] severance package totaled $7.8 million, to be paid until 2006.

lawyer the opportunity to negotiate a generous contract, in which his position as CEO of the health system would run until 2004.[98] Kelley was also beginning to conclude that all might not go well working for his new boss, adding to his desire to obtain significant concessions from the university. As for the dean's job, his appointment, if Rodin had not interrupted it, would end in 2001. His first term of seven years had lasted from 1989 to 1996. After the traditional review, he was reappointed to the usual second term of five years.*

As for the sacking itself, one faculty member called it "very nonclassy, a public humiliation of a man who is very sensitive to individual and group morale."† All agreed that Kelley left with integrity. "He'd done everything he could," said his close associate Mark Kelley. "We have great admiration for him. In retrospect, it was a great era."[48]

Despite their appreciation for what Kelley had accomplished, some of the faculty felt that it was time for him to go. "We were pleased that the other shoe had dropped and felt he should have gone a year ago," said one senior faculty member. "Bill was the sticking point, festering for some time. The Bill–Judy thing was embarrassing to the school and not appropriate." A clinical chair suspected that, if Kelley had been in Rodin's position, "he would have had zero tolerance for the losses" and would have fired his CEO even sooner than Rodin fired him. All agreed that Kelley had done a fine job as dean. One faculty member's statement that "Kelley's as good a visionary, judge of talent, and dean as one could hope to see" probably reflected the opinion of most of his colleagues.[16] College Hall, however, was thinking that his flawed performance as CEO had put the university's finances at risk and was threatening to affect the finances of other schools in the university.

Rodin met with the chairs and other senior medical school officials on the afternoon she relieved Kelley and with the medical faculty the next day to announce that she had asked Kelley to step down and had appointed Peter Traber interim CEO and interim dean. Other than saying that new leadership was needed, the president was "very circumspect" and would not say why she had discharged Kelley. She praised his accomplishments, saying, "Our achieve-

* In his discussions before accepting the job at Penn in 1989, Kelley understood that he would be eligible for a second seven-year, rather than five-year, term extending his dean's appointment through 2003. "This would be coterminous with my CEO appointment, which would be until 2003 plus one year sabbatical to 2004," he explains. "I was surprised when my reappointment to a second term as dean was only for five years ending in 2001."[97]

† Some of his colleagues wondered why, in view of his services, the university could not have waited until his term as dean ended in 2001, so he could have left more gracefully.

ments are really legendary throughout academic medicine, and it's a tribute to his leadership."[156] She added, referring to healthier days, "Bill turned around HUP and made it a source of wealth."[98] The *Inquirer* reported Rodin saying that the next round of changes would be better achieved by Traber, a popular and well-respected faculty member.[156]

"People were amazed at the choice of Traber," a senior faculty member said. He was young, had been chair for only two years, and had no experience in running a huge, complex medical enterprise.[108] "But he's someone we know and trust. We all wish him well." Although some members of the faculty wanted to try to get Kelley reinstalled, most concluded the decision was irrevocable, and as one senior member remembered colleagues saying, "At least there was Peter."[53]

Traber had come to Penn in 1992 to direct the gastroenterology (GI) division of the department of medicine.* A molecular biologist, Traber was instrumental in developing NIH-funded multidisciplinary research programs at Penn. He had taken a leading role in CPUP, had created full-time GI practices at Presbyterian Hospital when the health system bought it, and assigned full-time gastroenterologists to the Radnor practice that Penn had established in a Main Line suburb. All these accomplishments pleased Kelley, and his research appealed to the basic scientists.

Kelley had favored Traber's becoming chief of GI at Penn in 1992 and, five years later, after an internal search, had appointed him to the chair of medicine to succeed Edward Holmes, who was leaving Penn. These and other actions also brought Traber to the attention of Rodin and Barchi. When Kelley gave his trustees his annual list of successors should he become disabled, Traber was high on his list.[13] When Traber was named, Kelley told him, "You're my choice if there has to be one."[155]

All who know Kelley and Traber emphasize the similarities and differences between them. Both are extremely bright and capable. Few, however, would describe Kelley as warm, but that is what many call Traber. "He's a Bill clone, but kinder," says Brian Strom.[111] "He's interested in people and their families," says Stanley Goldfarb, who worked closely with Traber in the department of

* Peter G. Traber: B.S. (1977), Michigan; M.D. (1981), Wayne State; intern, resident, fellow (1981–1984), Northwestern; fellow in gastroenterology (1984–1987), faculty (1987–1992), Michigan; chief, gastroenterology division, (1992–1997); chair, department of medicine (1997–2000); CEO, health system and interim dean, medical school (2000), Pennsylvania.

medicine for several years before Traber appointed him interim chair when Traber assumed Kelley's position.[134] "Peter's not arrogant the way Bill comes across. He works hard at being a leader, is very shrewd, listens well, but keeps his own counsel and suspends judgment. Peter's more cautious than Bill, his thinking is evidence-based, data-driven, in keeping with his good science."[134] Several mention Traber's experiences as an all-state football player while a high school student and an undergraduate at Michigan, and that he is seen as having "the confidence of an athlete,"[134] or, as another senior faculty member put it, "Peter's physically imposing, a gentle giant you don't want to mess with."[48] Another sees him as not threatening, a "Teddy bear. We hope his style is suitable to the situation."

Traber was admired for taking a drifting GI division and making it "a research and clinical powerhouse" in the view of Sankey Williams, one of the division chiefs in the department of medicine.[53] "At our meetings, he asked the best questions, often on behalf of the whole place, not just his division, which is atypical for a division head. When I said something that was possibly useful, Peter would come up to me afterward and thank me, saying, 'I learned something.' His ego is well hidden. I never saw him angry except when the arm on the barrier at one of the parking lots came down on his car."[53]

The appointment seemed to be well received across the medical campus. "Peter has a light touch," said Les Dutton from biochemistry, "but he'll follow the same theme—'move forward.' An inspired choice."[49] At HUP, according to Garry Scheib, the hospital's executive director, "Peter agreed at once to come over and talk to my division. He made such an impact by emphasizing people."[79]

What was missing, many acknowledged, was age and experience in the business world, but several faculty members suggested that no one else at Penn was more suitable. "When Peter took over," observed one of the basic science chairs, "there was uniform feeling that he is a saint, but is he tough enough to handle the problems?"[44] Brian Strom emphasizes his and his colleagues' view of the health system after Kelley was fired in 2000: "We were close to melting down. Peter prevented it."[111] With the medical school in deficit, it fell to Arthur Asbury, deputy dean of the school of medicine, to make necessary cuts, but, for solace, senior faculty could turn to Traber, who "calms you down," says Strom. "We know he cares about academics."[111]

Traber's annual budget as chair of the department of medicine had been

$140 million; as CEO of the health system and dean of the medical school, he became responsible for $2.2 billion. Traber knew that the University of Pennsylvania Health System had lost $300 million in three years, and the trustees were asking "a 45-year-old guy to run things. I wasn't threatened, but then, Robert [Martin, the chief operating officer] left."[155]

Robert Martin* had come to Penn in 1997 to run CCA, the primary care subsidiary of the University of Pennsylvania Health System, which was then losing $40 million per year. Two years later, after reversing most of the losses and improving CCA's operation, Kelley promoted Martin to chief financial officer and then chief operating officer of the health system. However, when the Hunter Group returned at the time of Traber's appointment, Martin saw no place for himself at Penn and resigned.[101,160]† Martin applied for the position of CEO of the University of California, San Francisco (UCSF) Medical Center, which had become available with the resignation of the leading executives of UCSF Stanford Health Care, the teaching hospital formed by the merger of the Stanford University Medical Center and UCSF Medical Center.[120] Ironically, if he were chosen, Martin would succeed John Stone, the interim chief operating officer and an executive from the Hunter Group, which was temporarily directing UCSF while the merger was dissolving.

The presence of the Hunter Group at Penn was making Traber uneasy. In addition to prompting the resignation of Martin, whose abilities he admired, Traber saw the consultants "interdigitating themselves into everything and meeting with the president and the trustees. They were setting themselves up to run the place. The organization was terrified that the Hunter Group was back, and I was concerned that the faculty would be paralyzed," Traber recalls. "And then Robert resigned. It was a very bad situation."[155]

Traber told Rodin, Palmer, and Riepe that he needed Martin and not Hunter and would rather return to the department of medicine than continue as CEO if the consultants remained. Palmer carried out the necessary negotiations, and the second Hunter engagement ended. "We no longer needed

* Robert D. Martin, B.A. (1971), North Texas; M.A. (1975) and Ph.D. (economics) (1977), Southern Methodist; assistant professor of economics (1977–1980), Texas A & M; executive with various companies (1980–1989); chief financial officer, Scottsdale Memorial health system (1989–1995); chief administrative officer, Mayo Clinic, Scottsdale (1995–1997); with University of Pennsylvania Health System (1997–).

† Ironically, it was Martin, not Rodin as many thought, who had first recommended to Kelley engaging the Hunter consultants in 1999.[94] "I hired the Hunter Group September 1, 1999," says Martin. "They gave their report by November and left."[101]

Hunter to do what we knew had to be done," summarizes CFO Peter DeAngelis.[94] The departure of the consultants led to a "great sense of relief that the Hunters were gone," Traber remembers. "Everyone was energized to make things work."[155]

In College Hall, Rodin now had reason to hope that much of the tension that had developed between the university on the north side and the medical center on the other side of Spruce Street would now subside. She was heartened by Traber's statement that "we need to work with the university." No longer would she face the combatant that Kelley had seemed to be.[134] When Peter Traber was preparing to meet with Rodin, his face did not take on the hangdog appearance as had Kelley's when about to visit College Hall.[92]

Role of the Trustees

"Where were the trustees?" more than one observer of the health system debacle asked as these extraordinary events were unfolding.[150] "The trustees loved Bill because he made them feel good," observed Marna Whittington from attending meetings of the health system board.[58] He was helping to dispatch what Whittington and others felt was Penn's perpetual inferiority complex with respect to more famous and successful research universities.[58] As one of Kelley's staff put it: "Penn was never as great as it wanted to be, nor as bad as it appeared."[69]

Rodin acknowledges that "Bill captivated the trustees. They became his advocates. This was where he vetted his ideas. Most believed it impossible that he would make mistakes."[98,152] As a senior medical school faculty member said, "The board thought he could manage himself out of anything."[16]

"It seemed as if some of the trustees on the health system board had their own egos invested in Bill's success," provost Barchi said.[32] Kelley believed that he had earned his support from the trustees—most members of the executive committee of the health system board were deeply loyal to him[89]—by his fully disclosing the issues that he was dealing with. "I worked closely with them to get advice and to develop consensus on how to move forward."[97]

Whittington believed that Kelley successfully sold what he wanted to sell but "never wanted sunlight on what he was doing. He didn't want the checks and balances. It was always a struggle to get the data from him."[58] This was Whittington's opinion before she left Penn in 1992 and several years before the large losses appeared. Whittington feared that Kelley was exposing the university to exces-

sive risk.[114] She saw him "very ably maneuvering to disable much of the oversight process at the university" while securing it for the medical center.[58] Kelley finds this perspective "paradoxical. Indeed, it was Whittington who avoided the sunlight as the university's senior vice-president for administration, and it was one of my reasons why full disclosure with the trustees was so successful."[151]

Whittington also questioned whether the Kelley style "really fit" with the organization where he now worked.[58] "He wanted to operate as if he were in the business world—limousines, high pay, and perks,"[161] which Whittington did not believe was appropriate at a university.[58] One must remember, of course, that Whittington, the university's senior administrator when Sheldon Hackney was president, worked on the north side of Spruce Street where, as she puts it, "my job was to represent the whole university and to maximize each part without losing the whole."[58] Hackney acknowledges that Whittington and Kelley "didn't get along. It was 'neutron Bill' versus Marna."[161]*

When the deficits began, Kelley's intelligent and persuasive arguments convinced the trustees that he had the difficulties under control.[32] "Bill's so strong, so confident," said John Fry. "He had put Penn medicine on its feet in a very difficult environment and had a record of a sterling financial performance."[89] An aura of invincibility surrounded Kelley, and the executive committee approved many policies because of confidence in him.[89] "Bill was a 'phenom,' " said trustee Richard Worley, who saw the health system executive committee "largely a Bill Kelley fan club. He was superb at managing his board relationships so we would understand what he was doing and why. It was very hard for any board member to question him."[72]

In time, Worley came to realize, "we didn't ask Bill enough questions when things were going well."[72] His colleague on the health system executive committee, Robert Fox, agreed and said, "Prior profits led to less scrutiny and contributed to not getting to issues faster." When the losses first appeared, Kelley suggested that they would constitute "a short-term problem, and Bill would solve the problem."[77]

Rodin came to believe, as had Marna Whittington before her during better financial times, that Kelley "hid information from the trustees and used reserves to cover operating losses."[98] Kelley strongly disagrees with this statement. "My approach was to make sure the trustees were fully informed. I

* The sobriquet *neutron Bill* followed Kelley from Michigan to Penn as a reflection of his dominant character. Neutron bombs are reputed to kill the population but leave the buildings intact.

attempted to get to Rodin first with all the financial information and then moved as quickly as possible to inform key trustees such as Roy Vagelos unless she instructed me otherwise."[61]

She tried to uncover this information by asking questions of Kelley and his associates at the executive committee of the health system board and in individual meetings. Kelley saw this activity as evidence of Rodin's micromanaging.[2] She denies this characterization, believing that Kelley misinterpreted the purpose of her questioning, which she thought was part of her responsibility as president. John Fry agrees. By the spring of 2001, he had worked with her for six years as her executive vice-president and one year previously as a consultant. "She does not micromanage. She's tough but fair and has great stability."[159] "I'm not an expert on the nuances of health care," she explains. "What I was worried about were the questions I didn't know how to ask."[152]

Kelley's supporters on the health system executive committee disagree with Rodin's analysis. "Bill did not hide data from the board," longtime trustee Myles Tanenbaum insisted. "I knew as much about this as anyone. Judy told him not to share certain financial and operational things with the board until she made decisions,"[60] a limitation which Kelley confirms[97] but which Rodin denies.[98] Rodin claims that Kelley even delayed reporting the full magnitude of the losses to Roy Vagelos, "Bill's big protector."[98] Vagelos, who had warned Kelley that "if you lose money, you'll probably lose your job,"[75] would not be around for long to run interference for him since Vagelos's terms on the university and health system boards were ending. Kelley recognized what was coming. "I had the most powerful university trustees on my board. She wasn't going to let this continue," he predicted.[2]

The losses, which were revealed in June 1999, seemed "to appear overnight," unlike more typical university events, where "things don't happen fast, which is what people are accustomed to," in the experience of Paul Miller, the former chairman of the university trustees.[114] Comparing what was agitating the health system with the routine he was familiar with at Merck, Vagelos said, "The board at Merck would never have allowed the losses to have remained unknown. At good companies, they project forward and manage expenses."*

* Vagelos could compare, from personal experience, how universities and private businesses dealt with such problems. After receiving his A.B. degree from Penn in 1950, he went to medical school at the College of Physicians and Surgeons of Columbia University and was an intern and resident in medicine at the Massachusetts General Hospital in Boston. He then conducted research at the National Institutes of Health and at Washington University in St. Louis, where he was recruited to be

Miller and other trustees familiar with the for-profit world agreed.[72,114] At the health system, "which was not built and managed as a business," Vagelos detected an unwillingness to manage costs adequately.[75] "Some initial losses would have to be accepted," Vagelos said, "to protect the academic mission." With Kelley having great difficulty "slowing down on the academic side," Vagelos observed, "Bill believed and hoped that it would turn around through increased patient flow. The problem was that we were getting fewer and fewer dollars for more and more patients."[75]

James Riepe, Vagelos's successor as chairman of the university trustees, holds himself and his colleagues partly responsible for "not recognizing the seriousness of [the losses] early enough. It was almost unreasonable to expect the board to second-guess someone like Bill."[121] This difficulty may partly have reflected the absence on the health system board and executive committee of other senior leaders in academic medicine, people holding jobs like Kelley's. Such individuals might have questioned the CEO more authoritatively about his decisions and recommended potential solutions in time to prevent some of the losses.

Actually, influential trustees were looking with increasing skepticism at what the health system executives, particularly Kelley, were saying. "Scrutiny was intense," one of the health system executives remembered.[94] When Kelley said that he should not institute all the cuts recommended by the Hunter Group,[105]* some of the trustees wondered whether he was fully committed to recovery over the long haul. The trustees who loved him when the dollars were flowing now began to doubt him.

The Environment Changes

Providing the health care for a sufficient number of patients to be able to influence what the insurers paid dominated the thinking of the health system's leaders. At its peak, however, Penn controlled only 14 to 18 percent of the market, giving it, according to health care consultant Gerald Katz, "limited

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chairman of the basic science department of biological chemistry in 1966. He moved to Merck in 1975 to direct its research division, became CEO of the company in 1985, and chairman the next year. He retired from these positions in 1994. Vagelos was elected a member of Penn's board of trustees in 1988 and served as chairman from 1994 to 1999.

* Eventually, "a large number" of the Hunter recommendations, according to Kelley, were not implemented by his successors "because they were viewed as inappropriate."[2]

market clout."[162] Combining with another large academic medical center like Jefferson, whose network involves 21 percent of the regional market,[162*] would have provided more strength when negotiating with the insurers but would probably have brought antitrust action by the federal government.[79] Kelley himself pointed out, "It's very hard to get enough market share to be worth all the effort."[2] Russell Palmer adds, "We have a classic consolidating market. You must be either big enough to be a truly major factor in the market or a niche player like CHOP [Children's Hospital of Philadelphia]."[14]

The framework upon which Kelley had constructed his health system, a vertically integrated delivery system to deal with capitation, was coming into question. Kelley had built his primary care network which, he had concluded, could be accomplished only by buying practices. "At the time, this didn't sound naïve," Sankey Williams remembers, "and Bill got a big press for his strategic vision and managing the system to fulfill the mission. Other schools asked, 'Why don't we have someone like Kelley?' "[53]

But the medical world in which Kelley worked was rapidly changing. Nearly full capitation, a prerequisite for success in a fully integrated system, never happened.[31] The fraction of patients covered with capitated contracts in the region peaked at about 55 percent in 1997 and then began to decrease. Fee-for-service agreements continued to cover the other half of insured patients. Ironically, in the opinion of another Philadelphia teaching hospital CEO, providers like Penn that had created bureaucracies costing large amounts of money to succeed in the world of capitation seemed to want to do capitated care more than did the insurers.[163]

"Our world is different than it was 10 years ago," the CEO of a large insurer told a reporter for the *New York Times* in July 2000. "In a tight labor market, employees are not happy about more cost-sharing. This is a luxurious time for luxurious products."[164] Patients were choosing point-of-service contracts, giving them greater flexibility in selecting their doctors and with fewer restrictions. In Philadelphia, the point-of-service contracts cost about the same as

* In 2001, the Jefferson Health System included, in addition to the downtown Thomas Jefferson University Hospital adjacent to the Jefferson Medical College, several leading suburban hospitals that were formerly part of an older corporation. The system operates in a community-based, decentralized method, and the corporate office appears to exercise less control of the subsidiaries than at Penn. Although Thomas Jefferson University and the Jefferson Health System are separate not-for-profit corporations, the two are closely linked. The president of the university is the chairman of the board of the health system, and an education and research committee, chaired by the dean of the medical college, advises the health system on academic and research activities.

capitated contracts. Consequently, the role of the gatekeeper controlling referrals and tests to save the insurer money in the classic capitated model was decreasing, reducing the need for the expensive infrastructure Penn had assumed was necessary to operate successfully in a capitated world. Adding to the plan, every time one of Penn's managed care patients wanted to be treated by a provider outside Penn, the health system had to pay their costs,[163] and, according to Kelley, was often unaware, for as many as several months, that the care was being provided by others.[61]

Furthermore, unlike in the days of unfettered indemnity insurance, the new methods of payment would not cover the high costs characteristic of teaching hospitals. HUP, like many academic hospitals, was also becoming the place of last resort for severely ill patients whose care was costly. Consequently, as Stanley Goldfarb put it, "when patient mix changed, the margins went."[134] The payers continued to dominate since there were only two of them, and overbedding in the hospitals further diminished the negotiating powers of providers like Penn. Insurers, consequently, no longer needed capitation to decrease what they paid to hospitals and doctors. U.S. Healthcare, for example, had no problem when Penn decided not to continue accepting capitated contracts.

Inexperience, however, would exact its price. "Previously, Penn couldn't spell primary care," said Mark Kelley, "and, like everyone else, we spent a lot of money on a primary care network."[48] Unfortunately, this approach proved less successful than anticipated, as the dean/CEO came to realize.[2]

Many thought that management was a big part of Penn's problems. "The market analysis was generally right," said Gavin Kerr. "Strategy was done at a high level but never translated into operational detail."[90] John Kepner reflected, "We did the capitated thing without experience in managing risk and with an information system that couldn't provide the data we needed. The managed care companies also had no experience and couldn't provide us with the data we needed to manage the care."[74,165*] Just having to administer different insurance plans for different practices complicated billing and physician compensation, among other activities.[31]

"In building a complex health system," Gavin Kerr says, the leaders must ask, "Does the size add value, and can you run it?"[90] Besides the expenses directly involved, the organizing and then installation of purchases and mergers require

* Kelley comments: "Some believe that the HMOs were threatened by the move of integrated delivery systems to provide full risk care, believing that if they were successful, direct contracts between employers and integrated delivery systems would emerge, rendering the function of HMOs redundant. Hence, they had little incentive to make this approach work."[165]

the effort of senior leaders with many other responsibilities which must, at least for the moment, be ignored or postponed.[120] "It's an opportunity cost.* People see synergies[166]† that don't apply," says Sandy Schwartz, who has studied such ventures.[16] "Bill got distracted by defensive strategies [in buying the hospitals]. You shouldn't overpay for assets because someone else is paying more."[16]

At the Wharton School, members of the faculty maintained that the entire strategic plan was flawed. "I told anyone in the health system who asked," said Mark Pauly, "concentrate on doing what you do better than the competition. That's what we teach in management 101."[167] Pauly had concluded that it was not sensible for academic medical centers to provide primary care in the suburbs, that they did not know how to do it well enough at competitive cost levels. "Health system officials apparently felt there weren't enough people to pay for tertiary care alone, that Penn could not afford *not* to establish an integrated delivery system. Kelley took the view, on numerous occasions, that Penn had to push into the suburbs to protect its source of clinical material."[167]

Another Wharton professor, Robert Burns, saw the situation as Pauly did. "Since everyone was buying the mantra in the early 1990s—where's your advantage?—everyone was putting together the parts without changing what's inside. One must pay more attention to the process of integrating than the structure of integration—it's all internal. The payers will simply play each off against each other."[50] Kelley retorts, "These academic perspectives sound good with 20:20 hindsight."[61]

Kelley's "Fatal Flaw"

Whatever the institution eventually decided to do, "one should continuously reassess the fundamental assumptions of the model," and Penn did not do so frequently enough, David Longnecker believes.[118] The university leaders agreed and believe that the very nature of Kelley prevented this. "Bill was so committed to his concept that when indicators began to shift, he wasn't willing or able to change course," says Barchi.[32] Rodin concurs. Kelley's "fatal flaw," she believes, "was his inability to adjust to changing times."[98]

* "Opportunity cost" refers to the cost of making an investment that equals the difference between the return on one investment and the return on another.

† Princeton economist Uwe Reinhardt remembers that somebody once compared synergies in hospital mergers to the phoenix, the legendary bird which, according to one account, lived 500 years, burned itself to ashes on a pyre, and rose alive from the ashes to live another 500 years. Neither synergies from hospital mergers nor the phoenix have even been seen.[166]

Trying to explain why someone with Kelley's talents found himself out of the job of his lifetime brought out the philosopher in several of his colleagues:

— "Great accomplishments and great failures reflected Bill's character."
— "It's endemic in some leaders that if you a have a grand vision, you overshoot."
— "He was so talented, he tried to do everything."
— "The guys who get you into it may not be the guys to get you out of it."

Wharton alumnus James Riepe, who, in addition to chairing meetings of the trustees of the University of Pennsylvania, works as vice-chairman of T. Rowe Price, the mutual fund company in Baltimore, observed, "I've never seen a growth executive who could succeed taking it down."[121]

Kelley, understandably, does not agree with these criticisms. It was he, Kelley claims, who started the retrenchment that the losses required. "We made major reorganization and restructuring changes along with the intense cost reductions beginning in the spring of 1999. My management team is the one she [Rodin] kept in place, and, indeed, they came very close to breaking even on operations during 2000, which was completed four-and-a-half months after I was fired. I think this speaks directly to the issue of my ability to respond to change."[2]

Despite the criticism leveled at the man who was steering the ship when it foundered, dispassionate observers emphasize that one must not minimize the effects on the health system of external influences beyond the control of any individual institution, such as the cuts in Medicare from the Balanced Budget Act and the impact of state Medicaid policies.[64] "These external forces exponentially heightened the complexity of achieving the objectives of Penn's health system in an already difficult market," said Andrew Wigglesworth. "Without them, I think a strong argument could be made that Bill would still be there."[64]

"The saddest tale is that this was Kelley's life. His whole ego was wrapped up in it," said Marna Whittington, one of Kelley's most consistent critics, but, she adds, "Penn is better off for his tenure."[58] His chairman at Duke and the former director of the National Institutes of Health, James Wyngaarden, who acknowledges being "a great admirer of his courage and command capabilities," agrees. "He made Penn the world-class institution it had every right to be."[6]

CHAPTER FIVE

After Kelley

On March 16, 2000, Peter Traber was confirmed as permanent CEO of the University of Pennsylvania Health System,[1] his other position as dean of the school of medicine remaining interim pending the results of the usual academic search. Traber and trustee Russell Palmer then convinced Robert Martin to return as chief operating officer of the University of Pennsylvania Health System. His office had been vacant for ten days.

Traber recognized that during the first years of his tenure, saving rather than spending would be his main concern. "We can't make good on all our commitments when scheduled," he acknowledged. "We'll have to wait and do it by priorities."[2] Newly appointed chairs, recent faculty appointees, and those yet to win grants would be given preference for whatever funds could be developed over chairs who had been at Penn for several years and more established investigators with NIH support.[2] "Now, the only way to get an infusion into one's lab," admits one of the former basic science chairs, "is to go somewhere else."[3]

Traber saw Penn's success in attracting NIH money continuing to grow in the next few years, thanks to the efforts of recently recruited faculty. The rate of

growth, however, was bound to slow from the recent high level of 14 percent per year—twice that of any other school[2]—as the lack of development funds prevented bringing new faculty to Penn. "I think it wise to damp down the NIH listing business," he suggested, referring to the yardstick that Kelley continuously trumpeted.[2] To some extent, Traber may have been responding to the reaction of some members of the Penn faculty and staff, "who treated Kelley's obsession about ranking as a joke," as one professor observed.

Traber doubted that Penn would continue to operate three acute care hospitals within twenty city blocks of each other. He saw Presbyterian, the closest to HUP, reducing the acuity of its beds, while HUP and Pennsylvania Hospital continued to deliver the level of care its patients had been accustomed to receive.[2] These decisions, however, awaited the advice of Traber's new strategic planning committee. The group would decide, among other issues, whether Penn should retain each of its community hospitals and where the capital, so badly needed at the hospitals and the school, would come from in the future, now that the financial role of HUP had changed from that of cash cow to deficit producer. Attention would be given to whether clinical programs should be shifted from one hospital to the other. The operating rooms at HUP, for example, were overutilized, those at Presbyterian and Pennsy underutilized.[4] One decision the committee had reached was to retain the suburban outpatient center at Radnor.[5] The Hunter Group had previously advised closing the facility.[6]

Clinical Care Associates

Another source for savings was CCA, with its 270 primary care physicians,[7] a basic part of Kelley's integrated delivery system strategy that he realized had become too expensive to continue in its current size and would need to be scaled back.[8] Although the capital spent to purchase the practices was gone forever, the expense of maintaining the practices could be reduced; when the doctors' contracts ran out, not all would be retained. The first to go were those whose productivity had flagged. Some had taken advantage of their unaccustomed full-time employment to work less hard. Several of these were senior physicians who received what one downtown specialist called "a nice preretirement package"[9] and were, in retrospect, not the wisest choices to have been brought into CCA in the first place.

The health system decided to retain CCA, but to decrease the number of

employed physicians to about 200, buy no more practices, and write no contracts exceeding two years. Despite this policy, however, many members of the staff and faculty felt, as did one longtime Penn officer who had been associated with the medical system for decades, "buying practices is like buying smoke. You take an entrepreneurial doctor and turn him into an uninterested employee."[10] To counter this tendency, CCA's basic operation would have to change. As described by senior medical director Ronald Barg, "We're moving to a franchise model as the contracts run out," thereby returning responsibility for running the practices to the doctors. "We are decreasing the centralized control. The corporate overhead is now one-third what it was."[7] As for the physicians' compensation, "each year," adds Barg, "we will adjust what we pay them by the success and the efficiency of their practices."[7] The university faculty benefit of full undergraduate tuition for dependents was no longer offered to CCA physicians hired after December 2000.[11]

Although the health system directed Barg and Kevin Mahoney, the executive director of CCA, to administer CCA to break even on operations during 2001 except for the assigned corporate overhead, the system expected that amortization and depreciation would continue to produce losses for CCA. Barg explains further: "Primary care practices as a part of the health system are losers because of the bureaucracy and the costs of teaching and research."[7] Furthermore, the income generated by referrals to clinical laboratories and radiology, which the private practitioner might perform in his own office to the direct financial benefit of the practice, now accrued to the health system's laboratories.[12]

Barg, who had practiced general internal medicine independently for more than a decade before joining the health system, speculates why Penn set up the CCA operation the way it did at the beginning. His conclusions are not charitable. "It's academic arrogance. The people at Penn thought they could do it better than the practitioners."[7] Former HUP chief financial officer Arthur Piper is not alone[13,14] in cautioning leaders of academic health systems: "You can't make money in primary care practices supported by capitated managed care. Penn failed to recognize that when you buy primary care doctors and remove their profit motive, their commitment falls."[15]

The University of Pennsylvania Health System was not the only health system or academic medical center in either Philadelphia or the country[16] that bought doctors' practices to boost admissions, overpaid for them, failed to manage them properly, and then lost money operating the practices.[11,16] Douglas Henson, who had worked at the Mayo Clinic's branch in Scottsdale,

Arizona, before coming to Penn as the CPUP executive director, found Penn "following the consultants' advice. However, the market was not moving toward capitation as they told us it would. Hospitals don't need to buy practices now," Henson believes, and adds, "If we didn't own the practices, we wouldn't buy them now."[11] Reflecting on his Mayo experience, Henson likes the Radnor concept and favors Penn's building more satellites. As for consultants, Henson says, "We must challenge their advice," and, in the future, "do more contingency planning."[11]

While CCA continues to give the health system executives financial heartache with its value in supporting clinical programs at HUP less than anticipated, the physicians in Penn's primary care practices have significantly assisted the clinical education of the medical students. CCA doctors teach a total of 18,000 hours per year, the equivalent of ten faculty members teaching full-time, and the students praise the quality of the experience they receive. "The students like it as much out there [at the CCA sites] as here [at the medical center]," according to Sankey Williams, the chief of general internal medicine.[17] This praise greatly pleases Kelley since, he says, "this was one of the major and, apparently, forgotten reasons for implementing the program to begin with."[12]

Some CCA physicians participate in clinical research, providing an important source of patients and data for Penn's investigators. When the health system considered scaling down CCA further or even closing it, researchers complained that such a move could significantly impede their work.

Phoenixville Hospital

When Penn bought the hospital in 1997, some at the medical center questioned the value or necessity for doing so since, by owning the dominant practice, Penn controlled the hospital by default anyway.[18] "It was the least necessary purchase," Will Ferniany believes, when comparing the purchase with Penn's merging with Presbyterian and Pennsylvania hospitals. "It's 30 miles away, a distraction, not part of our mission. We owned most of the primary care doctors, so why did we want to buy the hospital?"[19] As for Joel Eisner's practice group, Ferniany learned that "when we owned the practice and not the hospital, we had some control over both. Once we bought the hospital, the physicians had control over us by leveraging the hospital against us."[19]

And that is what happened. At a meeting of the Phoenixville medical staff on November 16, 1999, the doctors voted unanimously that the hospital should separate from the university.[20,21] Due to the fallout from the financial losses of the health system, the relationship between those at the community hospital and those at the university had greatly deteriorated. This action itself, of course, had no legal force. Divestiture, if it came, would be decided by Penn.

Reductions in personnel, dictated by the health system's losses, greatly irritated the Phoenixville loyalists. In October 1999, the hospital was ordered to save $1 million and cut sixteen positions from its 750.[21,22] Since the hospital was not yet losing money, local workers saw themselves paying the price for the mistakes made by the parent. The discharge of a brain-damaged worker became a *cause célèbre.*[23] The Phoenixville doctors sympathized with the hospital workers with whom they had a long history of collaboration. Among the most vocal was Joel Eisner, the most influential physician on the staff, who was becoming deeply disaffected with the merger, in which he had been involved in a major way. "The revolution began when Penn assigned budget cuts and reductions in staff to us," Eisner says. "Penn had agreed to invest in us, but actually our profits have been poured down their dark hole. The perception developed here that Penn was draining the hospital, destroying the community, and had no use for this highly productive hospital and its staff."[24] The Phoenixville loyalists also rebelled at paying the academic tithes to the university, which was not helping their hospital in return.[25]

There had been other gaffes as well, as Eisner saw them. The health system wanted the CCA practices to use the same computer billing service CPUP used.[26] "It wasn't suitable for our type of practice" or, Eisner thought, for the rest of the CCA practices.[24] Dr. Martin Harris, who was in charge of developing the health system's information systems at the time, agrees.* "Small practices are used to working with paper or maybe a Mac. Their people don't want to enter all the information a large system requires, so there's always a clear operating problem." Harris adds that "if the economics don't work for the practice, the practice won't use the computers."[27] Consolidating the information systems among HUP, CPUP, and CCA would remain a frustrating and unfulfilled hope of many of the senior administrators.

Another of Eisner's complaints was that, for some time, Penn was not billing for visits costing less than $100, a substantial portion of the charges his

* Harris now directs information systems at the Cleveland Clinic.

office generated. "It's Penn's hubris," Eisner says. " 'We know better' even though they've never done it."[24] Eisner's admiration for the business consultants Kelley had retained was distinctly limited—"nincompoops," he called one group. He found the guidelines being developed by the health and disease management group "idiotic," that the doctors putting them together "don't know squat about guidelines. They don't practice."[24] Eisner was annoyed that the Penn people did not call on his experience in managed care. He and some colleagues had formed an HMO in the mid-1980s which, when Aetna bought it in 1992, was worth seven times as much as when it started. These problems reflected, Eisner believes, the unwise "centralization of decision making in Penn Tower."[24]

Eisner's partner, cardiologist Paul Rogers, had given up most of his practice to work with CCA in its earliest days. After negotiating many of the deals to bring the physicians on board, he became disaffected with the concept, resigned from the CCA job in 1999, and returned to practicing in Phoenixville. "I differed with Bill too much because of the inefficiency, bureaucracy, ineffective bill collecting, bad contracts, and layers of overhead," Rogers explains. He saw Kelley wanting everything centralized and controlled by him.[28] In the process, Rogers adds, "we lost two generations of Philadelphia doctors who ran Mom and Pop practices. You can't put 50-ish docs together and have them be happy despite fancy facilities, and the referrals to HUP never came."[28] Medical school researcher Sandy Schwartz agrees. "You don't want to confuse an academic with someone who will get something done."[29] He asks why health system executives should think they can manage the offices of community doctors "when we can't manage our own specialty practices efficiently."[29]

Many at Phoenixville now think that the Penn system in its present form is failing.[30] "Economic realities have changed so that the health system is no longer a workable operation," psychiatrist Raymond Catton said to a reporter from the *Philadelphia Inquirer*.[30] Joel Eisner has concluded that universities cannot buy and run community hospitals and practices successfully. "The legacy of the 'LMDs'—what do *they* know—lives on," he says, using the acronym for the pejorative phrase, "local medical doctor," which university hospital doctors have long employed in referring to physicians in the community.[24] Eisner has found several of HUP's services to be "black holes" into which referring physicians lose their patients when they refer them to a teaching hospital. " 'Send them on down' is HUP's motto," but 'we won't send them back,' " is how Eisner characterizes some physicians in the Penn system. "I think Penn is realizing that the empire won't work."[24]

At health system headquarters, the executives see things differently. They believe that Penn put much more into Phoenixville Hospital than the loyalists there concede. Eisner's disaffection resulted, a senior health system executive holds, from the decreasing clout that he and his group could exercise as CCA grew. Initially, when Eisner's group was the largest voting block with the strongest administrative staff, his physician group could strongly influence CCA. Eisner's continuing power in his group related to the sale of PMA to Penn. "Joel made everybody rich, and they love him for it," one of the CCA leaders asserted.

School of Medicine

The budget of the medical school remained balanced in fiscal years 1998 and 1999. Year 2000 would be a vastly different story. When the health system began to lose money, transfer of funds from the health system to the school through the academic development fund (ADF) slowed and then stopped. The medical school had become dependent on the health system and the ADF for recurring expenses in addition to the large sums spent on capital improvements and recruitment of faculty.[31] Originally budgeted for $54 million in 2000, the ADF received only $17 million from the health system during 2000.[32] To balance the budget and make up for the loss of the ADF, the university loaned the school $24 million, on which the school was required to pay the annual service on the debt and the capital within fifteen years. Within its operating budget of $126 million, the school stopped recruiting new faculty, reduced expenses, insisted that faculty assign more money from their grants into salaries, and spent more from its endowment's income. The university matched the savings by contributing $3 million and supported the renovation of one of the laboratory buildings, a high priority for the school, which the health system had planned to do before the financial losses developed.[33]

As if these problems were not bad enough, the health system, which owns one of the buildings where school of medicine personnel work, started charging for rent, university maintenance, and operations. The school had hoped to save $800,000 from vacating space rented from the Children's Hospital of Philadelphia, but CHOP discovered that the university had not escalated the rent paid for the space during recent years, costing the school an unbudgeted $696,000. "No matter what we do to cut costs," says Michael Black, vice-dean for administration and finance in the school of medicine, "we keep paying for some other unprogrammed expense."[32]

Traber Leaves

On Thursday, July 26, 2000, five-and-one-half months after appointing Peter Traber to succeed William Kelley as leader of the University of Pennsylvania Health System and School of Medicine, President Judith Rodin announced that Traber would resign these posts at the end of August to become head of clinical pharmacology and experimental medicine at the SmithKline Beecham pharmaceutical company.[34,35] His boss there would be Dr. Tachi Yamada, chairman of research and development in pharmaceuticals, for whom Traber had worked at Michigan when Yamada was chief of the GI division and then Kelley's successor as chair of the department of medicine there. Yamada, a great admirer of Traber's abilities, had been trying to recruit him to the drug company before Kelley was fired.[35]

As temporary replacements Rodin appointed deputy dean Arthur Asbury as acting dean of the school of medicine and health system chief operating officer Robert Martin as acting CEO of the health system. Asbury, Barchi, Martin, and Rodin would meet together regularly, although Martin would relate more to the president, and Asbury to the provost. Asbury's and Barchi's roles would now be reversed. Barchi had been a member of the department of neurology when Asbury was chairman and had worked for him in the dean's office previously.[4] Although the university announced that it would conduct "a nationwide search for a single candidate to fill both posts,"[34] for the moment, the leadership of the health system and the medical school would be split, as many members of the blue ribbon committee had favored.

The medical school chairs and institute directors heard about the change at a special meeting quickly arranged for 10:00 A.M. on the following day. Traber read a statement saying that he had been offered a great opportunity, and that he was taking it. He invited no questions and left the room. He seemed very emotional, one of the chairs thought.[36] Asbury and Martin told the group that "everything would be OK, and that we should tell our faculty."[36]

The faculty and staff were surprised by Traber's decision since he seemed to be settling into his new job, different members saying:

— "He put his all into it. But then there was no meeting of his strategy committee in July and silence until this."
— "I would have laid dollars he wouldn't leave. I have no clues why he did."
— "He was growing tremendously in the job, even began talking 'CEO-talk.' "

"Peter was wonderful in his job," said Garret FitzGerald, chair of the department of pharmacology. "He did the most important thing. He calmed and stabilized the faculty. The last thing the university needed was for Peter to go." Reflecting on how Traber accepted the dean/CEO job in February, however, FitzGerald says, "He only had twenty-four hours to make up his mind. Only someone so young and inexperienced would do this. They took advantage of Traber," who was acting as "the good soldier."[37]

It was rumored, when Traber resigned, that he and the university had never settled the terms of employment under which he was working. "Those who hired Traber," observed one faculty member, "should never have let him take the job without defining the provisions for the position. Where were the trustees?" The chairman, Russell Palmer, after acknowledging that Traber is "one of the finest people I know," adds "he was thrust into it without the necessary training but gave it his all."[38]

Traber refused to discuss his reasons further. "Everybody has his own story," says Richard Tannen, "but they're not buying Peter's story."[39] Tannen, who worked closely with Kelley for several years, knows that the CEO/dean's job is "backbreaking. You don't have a moment to breathe. It's a tiger even for people who are experienced."[39] A senior faculty member who knew him well, in describing how Traber responded to the extraordinary pressures on him, observed that "he seemed all strung out, almost paralyzed by the demands of a job requiring eighty hours per week."

Traber, some of his friends at Penn thought, feared that he would have to spend most of his time with the health system rather than the school of medicine, and that the demands of the job would stop his research, which meant a great deal to him, as well as diminish his warm relationship with his colleagues on the faculty. In his new job, Traber would be called on to disappoint colleagues to whom Kelley had promised resources in more affluent times. Furthermore, it was likely that the finances of the health system and school would remain poor, at least for a while, and, consequently, the job would lose much of its potential for satisfaction.

It was true that the university and Traber never settled on the terms of a contract during the truncated period of his employment as CEO/acting dean. Throughout this period, the administration did not announce the names of candidates or appoint a search committee for the dean's position, an essential step before Traber could assume the leadership of the medical school on a permanent basis. In the words of one senior trustee member of the health system executive committee, "Judy stonewalled the contract. Peter was frus-

trated by having to spend so much time with Judy and John Fry. He couldn't have been more unhappy."[40] Rodin emphatically denies this. "I didn't stonewall the contract. When Peter asked to be permanent CEO, we did that right away. The dean's appointment had to go through the usual academic process," which can be a lengthy procedure taking much more time than the confirmation of the CEO position. "Peter and I agreed not to push it."[41]

In June, Rodin offered Traber a contract which stipulated that, if he was not selected as permanent dean, he would have to step down as CEO. Did this reflect Rodin's growing impatience with Traber's desire for greater independence in leading the health system? Many suspected that when Traber began asking for support from the university, the administration saw itself facing another Kelley, leading to a breakdown in the initial goodwill between Traber on one side and Rodin and Barchi on the other. On Traber's side, a faculty friend said, "It was most important for Peter to report to someone he trusted." At the end, some of his friends and colleagues wondered, did Traber face a classic "science versus administration" crisis, since the SmithKline Beecham job would include significantly more opportunities for him to express his scientific interests?

Kelley, not unexpectedly, believed that Traber's principal problem was the president and that he was facing the same problems as had his predecessor in dealing with her.[12] Rodin denies this.[42] Six weeks into the job, Traber had asked to be relieved, that the job was not for him, and to return to full-time research, teaching, and clinical care in the department of medicine as a professor but not as chairman again.[42] "I begged him to stay," says the president, which he did for four more months.[42]

As the turmoil increased, a major concern, particularly among the basic scientists, was that, because of its costs, the university would decrease the size of the research enterprise, the growth of which had been Kelley's foremost goal. They saw the senior administration forcing major cuts. One faculty member heard that provost Barchi had said, "What's wrong with being number 15?"—certainly a question one could never imagine William Kelley asking. Barchi explains that he had been quoted out of context because he also said, "so long as you're *number 1 in quality.*"[43] The provost recognized that maintaining Penn's standing in the NIH ranking, such an important criterion for Kelley, might not be possible. The university and the health system, in this time of financial turmoil, might not be able to develop the funds necessary to fill the gap between the costs of sustaining the large faculty of investigators whom

Kelley had recruited and the amount of income from grants that even the most successful investigators could generate. This might lead to Penn's retaining a smaller faculty, which was recognized, however, to consist of investigators, clinicians, and teachers of the highest distinction.[43]

Schaffer Leaves

Would the faculty decamp after Kelley was fired? This was a major concern among health system trustees and convinced many of them, at the time, that Rodin's action was unwise. For the most part, however, this did not occur, persuading some that their anxiety had been premature.[44] Kelley says that, even after his discharge, "I worked hard to keep Penn people from leaving."[45]

During the first year after Kelley's demise, a few faculty members left, the most senior being Priscilla Schaffer, chair of the department of microbiology since 1996. She had become discouraged with Penn and decided to go back to Boston to lead the laboratory of molecular virology at the Beth Israel-Deaconess Medical Center, one of the Harvard-affiliated teaching hospitals, and to a full professorship at the Harvard Medical School.[36]

Schaffer saw Kelley's Penn working well so long as the money was pouring in, "which is why he offered me such a terrific package."[36] The progress of the medical enterprise at Penn faltered "because there was insufficient fiscal oversight," and, Schaffer adds, "there's a leadership and vision vacuum at the top now with Peter gone and acting people in the top jobs."[36] She wondered how Rodin would be able to recruit someone with Kelley's skills and without his faults into the position he and now Traber had vacated. By her own choice, Schaffer would be watching but not participating in the future of medicine at the University of Pennsylvania.

Unease

The chairs and the faculty fretted over how to proceed during the interregnum. Nick Bryan was hampered—although he was eventually successful—in trying to recruit a chief of interventional radiology by his inability to spend from the department's $60 million reserve, which the health system had frozen to support its collateral. "To whom do I go to get it done?" he asks. "Who will back this position with Peter gone?" And, he wonders, "How can we recruit replacements for chairs?"[46]

"Anxiety is what the basic science chairs feel," said Les Dutton from biochemistry. "Kelley gave us a future. He managed with fairness and humor, even when things got bad."[47] "Recruiting has stopped so I can't develop some of the topics needed to create a critical mass," said Charles Emerson, whom Kelley hired to chair the department of cell and developmental biology in 1994 when money was plentiful.[48] "Without the dollars from the health system, the school's in debt and we can't build further. Morale is down because of the hold on dollars."[48] Faculty also fretted about the potential departure of more senior members. "It's the best and the best funded who get recruited and leave," acknowledges Sandy Schwartz.[29]

Building and replacing outdated equipment has, for the most part, stopped. Leaders, however, hope that they can, sooner rather than later, start construction of a badly needed new outpatient facility on the grounds of the adjacent convention center, now vacated for the new center downtown. "We'll have to rely on donors," says Douglas Henson. "We can't take on more debt."[11]

With the health system and the school of medicine managed separately, loyalists at the school feared that decisions made at the health system could adversely affect the school. "Kelley and Traber looked on the school as the crown jewel," says Michael Black from the dean's office, "but Martin and DeAngelis [senior health system executives] look on the school as a drain."[32]

While Traber was in charge, Penn seemed ambivalent about retaining the Phoenixville Hospital. "If Phoenixville wants to go, we'll let them go," was the message Phoenixville leaders were hearing.[25] On September 29, 2000, however, with Robert Martin now the interim CEO, Penn announced the retirement of Richard Seagrave, the executive director of Phoenixville for the past eleven years, and the appointment of Kevin Mahoney, the executive director of Clinical Care Associates, as his successor and Ronald Barg, the senior medical director of CCA, as chief medical officer. The Penn action was not well received by many of the doctors at Phoenixville. Paul Rogers saw it as "heavy handed, in your face."[28] Since Martin acted without consulting leading physicians at the hospital, Raymond Catton told a reporter from the *Inquirer,* "the people I have spoken to are appalled by this."[49]

By 2002, Presbyterian and Pennsylvania hospitals were breaking even on operations, although many of the Penn leaders persisted in wishing that the health system had never bought them. "There is little benefit in owning multiple hospitals in an environment where risk-based contracting does not occur," observed Stanley Goldfarb. "It is hard to see how this ownership contributes to

our core missions."[50] Rodin, however, continues to see Presbyterian as "part of our campus."[51]

The need for capital greatly concerns the university and health system leadership. "If hospitals can't recapitalize," says consultant Gerald Katz, "they run down."[52] Although some hospitals have modified or increased their debt by refinancing or borrowing through other agencies, The Philadelphia Authority had issued no new debt for hospitals since 1997.[52] The difficulty hospitals were experiencing in borrowing reflected, in the view of Andrew Wigglesworth, "the negative perception of Philadelphia's health care environment caused by the Allegheny and several other health care bankruptcies and Temple's and Penn's losses. Hospital bond ratings were being downgraded, and the bond insurance necessary to obtain favorable interest rates had become increasingly difficult for any Philadelphia institution to obtain."[16] Labor costs in the Philadelphia market remained high.[52] "Moody's and Blue Cross say," according to Katz, "fix your home, take out fixed costs by *really* closing beds and actually closing hospitals."[52] Observers continue to criticize the large number of groups performing expensive, highly specialized procedures in the region. For example, in 2000, there were thirteen organ transplant units in the region.[52]

The Next Kelley

After Traber left, Rodin, at first, sought to replace Kelley and Traber with a single executive who would direct the entire University of Pennsylvania Health System. Because of the special problems facing private universities, Rodin favored that the next CEO/dean come from a private academic medical center rather than from one of the state universities, as did Kelley.[42]

Like the search committee that had nominated Kelley more than a decade ago, the president fretted about the difficulty of finding an outstanding academic leader "with the abilities needed to run a major business."[42] Leading trustees agreed. "Most academic leaders are not businessmen," said Roy Vagelos, whose career in a medical school and in industry gave him experience shared by few other board members. "One person cannot do it. No one could be stronger than Bill, and he was not able to pull it off."[53]

Despite the difficulties in finding a suitable candidate, medical school leaders like Arthur Asbury, the interim dean and executive vice-president, agreed with Rodin's approach "because one person is needed to allocate the resources."[4] He

and others[4,40] saw the new leader spending most of his time, perhaps as much as 80 percent, in the dean's office and delegating much of the CEO portion to a chief operating officer for the health system.[4] The leader must not, as many saw Kelley doing, spend most of his time on the health system.[4]

Many, perhaps most, faculty members preferred that the university manage the medical school and health system under one leader, but feared that the momentum among the trustees toward change had become too strong to stop. Quoting former British prime minister Harold Wilson's comment, "A week's a long time in politics," Garret FitzGerald says, "The longer that Asbury and Martin separately lead the medical school and health system, the more likely the arrangement will become permanent." He and his colleagues fear that, if the split is finalized, the health system will dominate and "academic commitment may go way down the list of priorities."[37]

Kelley, a most interested party now watching from the sidelines, continued to favor the combined CEO/dean structure with an important proviso. "No question single management is best, but not if Judy's there. They'll search," he predicts, "but no one will want the job, if they'll split it. In addition, she won't be able to tolerate someone who's strong."[12]

Despite Kelley's reservations, the search proceeded. A suitable candidate, psychiatrist Dwight Evans, the chairman of the search committee, suggested, could include an academic leader now functioning as:[54]

- a chair running a large clinical operation
- a current dean with a background leading a clinical department
- a current dean/CEO
- a current hospital or health system CEO, "but this is a tougher sell here because of Penn's commitment to academic values," requiring that the dean have strong academic credentials[54]
- a current pharmaceutical or biotechnology executive with a background in academic medicine

Tachi Yamada added, "The new person has to realize that Penn is greater than the medical center. Rodin's job is to keep Penn one of the nation's great universities and prevent the finances of the medical center from hurting the university. Anyone who thinks the medical center is more important than the university will be in trouble."[35]

As the search continued, Rodin took steps to strengthen the oversight that

the health system trustees would exercise over the work of the next CEO. The budget and finance work would now involve the entire board through a committee of the whole rather than a smaller group, as was the case in Kelley's day. "We've bolstered the audit committee," and, Rodin adds, "we'll change the membership and its leadership more often."[42]

The Trustee/Faculty Committee

Even as the search committee began its work, aided by a search firm, Rodin continued to ponder the basic relationship of the health system to the university. Accordingly, in December 2000, she appointed a special committee of trustees and medical faculty,[55] chaired by her, "to focus on possible changes in the structure or organization of UPHS [University of Pennsylvania Health System] that could protect and enhance the academic mission of the School of Medicine, position UPHS to compete effectively in the commercial marketplace, and enhance its ability to raise capital."[56]

Immediately, the faculty speculated that big changes were coming. The same month in which the committee began meeting, the rumor of a possible purchase of the health system by Vanguard Health System of Nashville,[55] a for-profit company, alarmed many in the medical community. According to university officials, Rodin neither initiated the discussions nor suggested that Penn negotiate with Vanguard.[57] Nevertheless, the story remained alive for several months, prompting one faculty member to suggest, "How smart of Judy to raise the specter of the health system's merging with a for-profit company. This will convince the faculty to accept HUP's being spun off as an independent, not-for-profit corporation."

More practically inclined faculty members wondered that if the health system should separate from the medical school and the university:

- Would the clinicians, even more than in the past, concentrate on "what's in it for me" whenever the separately managed health system decided something that could potentially affect them?
- Would separate management "devalue the influence of the clinical chairs," reducing their ability to recruit outstanding colleagues and lessening the ability of the university to attract superb candidates to replace them?

— Might independent health system leadership open HUP to privately practicing physicians and surgeons, thereby reversing the full-time policy established with much turmoil during the past thirty years?
— Could the Flexnerian ideal for training doctors be maintained with HUP under separate management?*

Despite these concerns, leading trustees continued to favor separate governance.[53] Mitchell Blutt, the physician-turned-venture capitalist, asked, "Does the university really need a health system representing half of the endowment and more than half of the operating expenses and at risk of taking big losses?"[58]† Riepe added that the events that brought Kelley down "highlight the problems in running a commercially viable venture in a university."[59]

"Part of Kelley's problem was the basic structure," John Ball, the former CEO of Pennsylvania Hospital, believes. "In making decisions, he was arguing with himself" since he did not have an independent dean and director of the health system. Consequently, in view of his orientation, "disputes were settled in favor of the academic side."[60] Ball, who is trained as both a doctor and a lawyer, believes that an institution needs proponents for different entities presenting their best arguments to the boss.

The Committee's Decision

On February 16, 2001, the trustees received a report from the trustee/faculty committee recommending that the university establish,[61] as President Rodin e-mailed to her colleagues, a "new not-for-profit [501(c)(3)] entity wholly owned by the university . . . for the health system" with "its own CEO and governing board."[62] The medical school would continue to be an entity of the University of Pennsylvania. CPUP, the full-time faculty's practice plan, which organizationally had become a part of the health system, would return to the jurisdiction of the medical school and its dean.[57,63] Rodin's memo also stated that "the university is committed to maintaining an integrated health system.

* Abraham Flexner, in his study of the country's medical schools published in 1910, concluded that Johns Hopkins, with its close integration of school of medicine and teaching hospital, provided a particularly fine model for training medical students.

† In 2001, the total revenue of the entire medical enterprise, including the $400 million from the medical school, was about $2.2 billion, according to Kelley, significantly more than the $800 million from the rest of the university.[12]

Consistent with this commitment, the trustees have reached a decision not to sell any of the hospitals of the health system."[62]* Rodin added, in a statement to the *Inquirer,* that the decision "reaffirms what we hold most dearly . . . the central academic mission of this institution. This is America's first university.[65]† It is America's first medical school. HUP is America's first teaching hospital. Pennsylvania Hospital is America's first hospital. You know the litany, but it is real, and it is absolutely formative in framing our thinking."[67]

The committee had considered several organizational arrangements, ranging from what one member called "the extremes of doing nothing, the 'status quo' solution," to selling the health system to a for-profit company, a decision that might provide the most capital but was fraught with major cultural objections from the faculty, most of whom adamantly opposed such a solution.‡ More moderate possibilities included divesting part of the health system from the university, affiliating with an already existing not-for-profit hospital system (selling the health system to Children's Hospital of Philadelphia caught the campus's fancy for a while), and the solution the group adopted.

The committee met for six times in a conference room in the Rhoads Building, Kelley's marble-clad addition to HUP. Rodin chaired each session and impressed the group with her understanding of the issues and problems. The committee members appreciated the thoroughness with which the various options were presented by the university's and health system's staffs and consultants. Rodin remembers how "the faculty had enormous input. Most of us changed our points of view at least once, the signs of a good process." It was not, she recalls, "IDS [integrated delivery system], the sequel, but, rather, how can we sustain a quality academic medical center?"[51]

* "A triumph for Bill Kelley's vision and the value of it to the university's academic mission," thought trustee and Kelley supporter Susan Catherwood.[64]

† This is a claim long made by Penn's presidents. The College of Philadelphia first called itself the University of Pennsylvania in 1791, when it merged with a short-lived establishment named the University of the State of Pennsylvania, which had been founded twelve years earlier.[66] If the presence of more than an arts faculty defines when a college becomes a university, then King's, later Columbia College, with the second oldest medical school (1767), or Harvard, which started its medical school in 1782, could also have adopted the title. They did not. Columbia remained, in name at least, a college until 1891.[65] Harvard began referring to itself as a university by the middle of the nineteenth century, although its corporate title remains, to this day, "The President and Fellows of Harvard College."[65] Thus, although Penn was the first to officially use the university designation, it was not the only American institution functioning as a university at the time.

‡ Sale of the health system "would cause Benjamin Franklin [Penn's founder whose body was interred more than eighty years before HUP opened] to roll over in his grave," one basic science chair suggested.

Faculty participants, however, made it clear that "many top people" from the medical school would leave if the university "sold out" the health system to an external entity. To the question, "Were we being set up?" a participant from the faculty said, "No. There was nothing cynical about it."

The reaction of the faculty to the committee's decision differed greatly from the turmoil that had attended the actions of the blue ribbon committee the year before. "Relieved but wary" is how Dr. Alan Wasserstein, president of the steering committee of the medical faculty senate in 2001 and a member of the committee, described the response of his colleagues.[68] Most were pleased that the university, not an external for-profit or not-for-profit entity, would still control the health system within the new corporate structure.

In reflecting on what accounted for the faculty's receiving calmly the work of the second committee while the blue ribbon committee's proceedings had angered them, most replied that the difference was participation. This time, faculty members had helped create the formula that would preserve the academic features so important to the professoriate. The unanimous opposition of the chairs during the previous year also reflected their not comprehending, as many did now, the financial problems the university faced. Furthermore, the university leadership had learned from the trauma that followed the deliberations of the blue ribbon committee. The second time around, the issues Penn's health system faced were explained to the satisfaction of faculty leaders, producing the general support for the committee's conclusions. Rodin recognized the difference. She told a reporter for the campus newspaper, "I think the sense of being excluded contributed to the reaction," but added that the absence of William Kelley might also have affected the faculty's change in attitude.[69] Alternatively, Kelley suggested, "the faculty don't actually understand what is being proposed."[12]

On the day before the recommendations of the trustee/faculty committee were presented to the trustees, provost Robert Barchi met with the chairs, many of whom were his former colleagues in the medical school when he worked there, and explained what the committee had determined. Rodin then personally thanked each committee member individually for assistance and participation, an action much appreciated by those involved.

Creating a new corporation addressed several of the concerns of influential board members, and, in effect, implemented the solution that most members of the blue ribbon committee had favored a year before. Although the university would become the sole member of the new corporation, the leaders of the

health system would, it was hoped, be able to carry through decisions more rapidly and efficiently by avoiding the delays inherent in the university's bureaucracy. Although the solution offered no magical answer to the need for capital, the reconstructed health system would be better managed, most expected, so that, in time, surpluses would again appear, debt would be paid down, and investment would be promoted through cash flow, new borrowings, and charitable and possibly governmental contributions.

The structural organization having been decided, the search for the CEO/dean was converted into a search for a dean/executive vice-president who would primarily lead the school of medicine and influence, but not direct, the health system. To assure stability in Penn Tower, Rodin appointed Robert Martin, who had led the health system on an interim basis since Kelley's discharge, as permanent CEO.[70] Martin's appointment, announced on May 14, 2001, would require confirmation by the new board of trustees of the health system when this group would be constituted in about a year.[51]

Although the new arrangement may have pleased the trustees and calmed the faculty, some were not so sure that Penn had found the best answer. Consultant Gerald Katz concluded, after hearing about the university's decision, "Nothing really has changed. They just rearranged the chairs. . . . They haven't changed the outstanding-debt situation, and they haven't really changed the economic formula there."[61] Another health care consultant, Joshua Nemzoff, doubts that the new corporation will really shield the university from future financial problems. "Whoever is telling the board they will be protected is wrong," he warns.[71] With Penn's executives and trustees controlling the health system by appointing its trustees through its single membership, bondholders, the consultant believes, will look to the university for payment if the hospitals should default. Nemzoff also doubts that the new arrangement will allow the health system to speed its decisions into action. "Won't the university board and officers still want to review its biggest decisions?" he asks.[71]

Whether or not the president and other university officers would exercise a major influence on the health system in the more distant future, the present condition of Penn medicine continued to dominate the thinking of the university's leaders as the search for Kelley's successor proceeded. "We're so focused on health care, at times, often to the detriment of other university issues," said executive vice-president John Fry,[72] whose time at Penn was about to end. During the summer of 2002, Fry would become became president of Franklin & Marshall College in Lancaster, Pennsylvania.

Kelley's Day

On March 23, 2001, thirteen months after he became a professor of medicine without administrative responsibilities, Kelley's portrait was unveiled, a tradition at Penn for senior medical professors. The painting shows the former CEO/dean standing behind a desk on which rest his medicine and rheumatology texts. Through the window on his right is shown BRB II/III, one of Kelley's creations, where the ceremony was held and where the portrait would later hang. Several of Kelley's friends would unsuccessfully petition the university administration to name BRB II/III for him.

Earlier that afternoon, the university held a symposium titled "Predictions for the New Millennium" in Kelley's honor. The speakers included Samuel Thier, CEO of Partners HealthCare of Boston; Kenneth Shine, president of the Institute of Medicine; Roy Vagelos, former CEO of Merck; Gail Morrison, vice-dean for education; and Francis Collins, director of the National Human Genome Research Institute at the National Institutes of Health. Kelley, Shine, and Thier had met when each was training in the 1960s at the Massachusetts General Hospital, where Vagelos had been a medical house officer in the previous decade.

After shaking hands with Kelley, university president Judith Rodin welcomed the audience, which filled the 240-seat auditorium in BRB II/III, and then introduced Edward Holmes, the chairman of the symposium. Holmes, vice-chancellor for health sciences and dean of the school of medicine at the University of California, San Diego, had graduated from Penn's medical school, trained in Kelley's laboratory at Duke, and been Kelley's chair of medicine at Penn. Rodin, reading from a script, stumbled over Kelley's name, the only glitch in a gracious speech. She ascribes the slip to her discomfort when she saw Kelley's wife leaving the room,[41] presumably, in protest to her presence. Rodin remained for the symposium, sitting in the front row below the podium next to Peter Quinn, a senior member of the faculty, a particularly close associate of Kelley at Penn and one of the planners of the event. When the talks were over, Rodin returned to her office and did not attend the portrait ceremony.

That evening, 197 friends of Bill gathered at the Four Seasons Hotel, Kelley's favorite recruiting site, for dinner and speeches. Nostalgia and emotion were in the air. Trustee Myles Tanenbaum, partially overcome by the occasion, had

difficulty finishing his speech. Russell Palmer, chair of the executive committee of the health system board, observed, to prolonged applause, "Given the time, he would have completely solved the [financial] problems."

Others at the dinner and during the symposium gently roasted the honoree.

Kenneth Shine, reflecting on their time together as trainees: "As a teaching resident, he was already a dean." (Laughter)

Peter Quinn: "We [the clinical chairs] would meet at 7 A.M. and debate Bill's recent decisions. Then Bill would arrive at 8 and tell us what we would discuss at the next meeting." (Laughter) "He invited everything—everything but questions." (Laughter)

Roy Vagelos: "I met Bill at the NIH when he took a course in advanced biochemistry that I was teaching. We both survived." (Laughter)

A New Dean Appointed

On July 30, 2001, sixteen months after William Kelley had been relieved, the university announced that Dr. Arthur Rubenstein, dean of the Mount Sinai School of Medicine in New York City since 1997 and an authority in diabetes—a "seasoned pro," as the *Philadelphia Inquirer* described him[73]—had accepted the positions of executive vice-president for the health system and dean of the school of medicine, effective September 1, 2001. A graduate of the University of Witwatersrand in Johannesburg, South Africa, Rubenstein had spent most of his career at the University of Chicago, where he was chairman of the department of medicine for sixteen years beginning in 1981.

Rubenstein and his predecessor have important similarities and differences. Both are equipped with high intellects, both had distinguished careers as medical investigators, and both had directed departments of medicine at leading research-oriented medical schools. Their images, however, differ. Whereas all see William Kelley as a no-nonsense, forceful executive, Arthur Rubenstein projects a more reserved, gentle character, more like Edward Stemmler, Kelley's predecessor.*

Rodin and Barchi, in their letter to "The Penn Community," announced that "Dr. Rubenstein will report to the president in his capacity of executive vice president and to the provost as dean." Most important, the letter declared,

* Is there a cycle in these appointments, "an oscillation," as Kelley refers to the pattern,[8] from the calm reserve of Stemmler to the dominance of Kelley to the composed approach of Rubenstein?

"Robert D. Martin, Ph.D., the Health System CEO, will report to Rubenstein."[74] Thus, the direction of governance turned further from the course outlined by the trustee/faculty committee. Rather than primarily leading the school of medicine and influencing, but not directing, the health system, Rubenstein would have direct responsibility for the entire medical enterprise, thereby acquiring all the authority exercised by Kelley but without the title of CEO. Rubenstein, who had been offered the presidency of the Mount Sinai Medical Center, had informed Rodin that he would not come to Penn just to be dean,[75] which was also Kelley's response when asked if he would be interested in succeeding Edward Stemmler as dean of the school of medicine in 1988.*

After settling into the job, Rubenstein estimated that he spends approximately equal amounts of time on medical school and health system work, but, unlike Kelley, who officiated from the "Tower of Power," Rubenstein works from the traditional dean's office in the school of medicine.

Kelley professed great pleasure in Rubenstein's selection. The two had known and worked with each other for many years. Kelley was pleased that Rubenstein would be taking the position with the governmental structure he favors. "They had to keep the whole thing together to make it a good job," Kelley says. "Judy will have to support him since she appointed him."[76]

Penn Medicine

In November 2001, Rodin described a new structure for the medical center. The university trustees would create an entity called "Penn Medicine" to include the three medical enterprises owned by the university: the school of medicine, CPUP, and the clinical entities (consisting of HUP, the three other owned hospitals, the primary care practices, and the miscellaneous clinical activities Penn had acquired). A new board, empowered by the university, would exercise authority over all three under the rubric of Penn Medicine.† The new scheme would, in addition to its more fundamental features, relieve the university executives of attending several monthly meetings of the various

* Each of the finalists, whose names the search committee submitted to Rodin and Barchi, insisted on having authority over the health system as well as the school of medicine and practice plan.

† William Kelley's response to these developments was: "Basically, after two years of intense (and often very disruptive) discussion and debate to separate UPHS in various ways, this proposal is essentially the same as where we were two years ago. Penn Medicine is virtually identical to UPHS as I had defined it and had used it since it was formally approved by the trustees in 1993."[77]

health related boards, an activity which, Judith Rodin said, "certainly didn't use our time wisely, but that is what we did."[78]

By 2002, the health system and its hospitals were no longer losing money, and Moody's investment service raised its grading of the debt of the university and the health system from "negative" to "stable."[79] The debt of $800 million carried by the health system, however, precluded further borrowing. Consequently, surpluses from operations and philanthropy provided the only sources for capital improvements.[80]

Nevertheless, the health system administration was not talking about selling any of the hospitals. The size of CCA, however, had decreased. The number of physicians dropped below 200, a reduction augmented by the departure of Joel Eisner's medical group at Phoenixville, which bought themselves out of their contract with the health system effective in the beginning of 2002. "We were tired of Penn, its bureaucracy and bookkeeping," Eisner said. "It cost us to get out, but we would have done it regardless of the cost."[81] Douglas Henson, who now administers CCA in addition to CPUP, anticipates the number of doctors in CCA remaining at about the current number. Despite a budgeted loss of $7 million in fiscal 2003 and a projected loss of $3 million in 2004, the health system continues to believe that owning the remaining practices adds value to the health system through referrals of complicated cases to the owned hospitals and to the medical school by providing opportunities to teach clinical medicine to the students.[80] "We believe they're worth the loss," says Henson. However, when asked if Penn would now institute CCA from scratch, he adds, "We would find better uses for the capital."[80]

In the spring of 2002, Robert Martin revised the administrative structure of the health system, giving Garry Scheib, the executive director of HUP, responsibility for all the owned hospitals and the management of CCA and the home health units to Henson. Six senior executives would now report to Martin: Henson; Scheib; Peter DeAngelis, the CFO; Will Ferniany, the senior vice-president for administrative and network services; Allan Rosenberg, the chief of staff; and Dr. David Longnecker, occupying the new position of chief medical officer of the health system.[80*]

* On October 10, 2002, Robert Martin announced that he would resign the position of CEO of the University of Pennsylvania Health System at the end of the 2003 fiscal year on June 30. In departing the job, Martin would become the third CEO to leave since William Kelley was fired in February 2000 and Peter Traber resigned five months later. "The time has come . . . to seek a new challenge," Martin told *The Daily Pennsylvanian,* the campus newspaper, although what that challenge would be

Whether to create a separate 501(c)(3) corporation for the health system would be decided later.[75,77,78,82] One issue complicating such a development involved CPUP. On the books, the practice plan was accounted as part of the health system, not the medical school. Its $380 million in annual income improved the financial status of, and helped to sustain, the $800 million debt carried by the health system.[75] Since practice plans collect the professional income generated by the full-time faculty and help to pay their salaries, the medical school would require CPUP if a separate corporation were established, thereby seriously injuring the finances of an independent health system.[75]

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remained unannounced. Several senior members of the university administration, including dean Arthur Rubenstein, praised Martin's performance although "Rodin [as yet] had no comment on Martin's decision, according to the newspaper.[81a]

Martin was succeeded as CEO of the University of Pennsylvania Health System by Ralph Muller, formerly president and CEO of the University of Chicago Hospitals and Health System.[81b] Rubenstein, to whom Muller reports, had worked with the new CEO when Rubenstein was chairman of the Department of Medicine at the University of Chicago medical school. As for the faculty practice plan, "CPUP answers to both the Dean/EVP [Rubenstein] and the CEO (for different matters)," Rubenstein explained. "As the organization is now [April 2003] set up, Ralph answers to me and so in practice CPUP answers to me anyway, either via Ralph or directly."[81c]

On June 20, Judith Rodin announced her resignation as president of the University of Pennsylvania effective at the end of the 2003–2004 academic year.[81d]

CHAPTER SIX

Separate Governance

In June 1995, the *Baltimore Sun,* the city's principal newspaper, ran a story that revealed to the public that all was not well at its leading medical institution:[1]

> Two Hopkins titans, hospital President James A. Block and the dean of the School of Medicine, Dr. Michael E. Johns, are engaged in a fierce struggle.
>
> Once friends, they have quarreled over power and issues affecting their separate jurisdictions. Dr. Block, though president of the hospital and the Johns Hopkins Health System, has no authority over the medical school and its 1,000 faculty physicians.
>
> The School of Medicine is a powerful, nearly autonomous division of the university. The dean rivals the hospital president in influence on the East Baltimore campus.

Sun readers now knew what most at Hopkins knew. A serious conflict between the leaders of the Johns Hopkins Hospital and the Johns Hopkins University School of Medicine was roiling one of the country's most respected academic medical centers. "In twenty-three years, I've never seen anything like it," a senior faculty member[2] remembers the director of one of the clinical

departments saying at the time. The resolution of this conflict would lead to a fundamental restructuring of the governance of the two institutions and how they related to each other.

Two Corporations

The organizations that James Block and Michael Johns would lead were founded by one man, Baltimore merchant Johns Hopkins.[3,4] In August 1867, the General Assembly of the State of Maryland created, at his request, two corporations, "The Johns Hopkins Hospital" and "The Johns Hopkins University." In doing so, the legislature gave formal recognition to the donor's wish to establish separate structures for his two legacies. Although hospitals had formed their own medical schools in London and New York, only with the construction of the Hospital of the University of Pennsylvania in the next decade would an American university with a medical school first build its own teaching hospital under the authority of the university's corporate structure.

Hopkins, said to have been the richest man in Baltimore in his time, had built a fortune of approximately $7 million when he died on December 24, 1873, at the age of 78.* A significant part of this wealth derived from shares in the Baltimore and Ohio Railroad, of which only the State of Maryland and the City of Baltimore owned more shares than Hopkins.[4] Never having married, Johns Hopkins allotted most of his assets equally to the founding of a university and a hospital, each to bear his name.† It was, at the time, the largest philanthropic bequest in the history of the United States.

The donor himself selected the site for the hospital on Loudenschlager's Hill in the eastern section of the city, a portion of which had been occupied by hospital buildings since the end of the eighteenth century. The State of Maryland had decided to move "The Maryland Hospital for the Insane, at Baltimore" to new buildings in the country, and Hopkins, who was a member of its board of visitors, agreed to buy the property for $150,000, the debt then owed by the institution, on condition that the city permanently close the

* See the Web site in reference[4] for the obituary of Hopkins published in the *Baltimore Sun*, December 25, 1873.

† Hopkins was named after his grandfather who had the same name.[4] Their first name derived from the family name of Margaret Johns, a paternal great-grandmother of the founder. The Johns family immigrated from Cornwall, the westernmost county of England, where the name is fairly common. The terminal "s" is a contraction for "son," hence, "son of John."[5]

streets that lay within the property. He gave the land to the new hospital corporation, while instructing his trustees,[3]

> I have given you in your capacity of trustees, thirteen acres of land, situated in the city of Baltimore . . . upon which I desire you to erect a hospital. . . . In all your arrangements in relation to this hospital, you will bear constantly in mind that it is my wish and purpose that the institution should ultimately *form a part of the medical school* of that university for which I have made ample provision by my will [my italics].

Hopkins's statement that he hoped the hospital would eventually "form a part of the medical school" would be periodically trotted out by deans of the school of medicine when their differences with the hospital's leadership peaked. What the founder intended to imply, probably, was that the hospital would become part of the medical school functionally, not governmentally, since he had specifically assigned the medical school to the university and its trustees and not to the hospital and its trustees—not that this distinction had much meaning at the time. Of the original twelve trustees of the hospital, each selected by Hopkins, nine were also charter trustees of the university. That the hospital and medical school functioned closely together was confirmed by Abraham Flexner in his review of the country's medical schools (1910) in which he praised what he found at Hopkins and described the hospital as "actually an integral part of the medical school."[6*]

The hospital finally opened on May 7, 1889, and, a week later, admitted its first patient. Twenty-two years had passed since its founding and sixteen years since the death of its creator. The university had taught its first (nonmedical) students in 1876, and, although excavations for the hospital began the next year, twelve years would elapse before the first patients arrived, the delay explained by the policy of the hospital trustees to spend only from income, not from the body of the endowment[8]—the same provision applied to the university[9]—and because the annual return on the endowment had shrunk.[10] What they built, although smaller than the original plans, was said to be the largest hospital in the country at the time[11] and included 330 beds, 25 physicians, 200 employees, and an annual operating budget of about $85,000.[12]

* Flexner confused the administrative relationship of the hospital with the medical school. In a more detailed report (1911) he wrote, "The plant of the Johns Hopkins Medical School consists of (1) Certain laboratory buildings; (2) The Johns Hopkins Hospital."[7]

With high ceilings inside and cupolas outside, the Administration Building, facing the wide, divided Broadway, was and remains a striking edifice. Designed in the Queen Anne style and faced in brick and sandstone, the building centers on a large rotunda, which reaches to a dome that has become the symbol of the hospital. North and south of this central area stretch wide halls surrounded by grand meeting rooms and offices. When the hospital opened, and for decades afterward, resident physicians and surgeons lived on the upper floors. In one of these resident's rooms, which he appropriated for his literary use, Dr. William Osler, the first professor of medicine and a renowned figure in medicine and in Hopkins lore, wrote his textbook on medicine, which became the leading authority in its field at the time.[13]

The man who proposed this plan was, as much as anyone other than Johns Hopkins, the creator of the hospital. Dr. John Shaw Billings, a physician with the Office of the Surgeon General of the Army whom the trustees retained to design the hospital, had become a leading authority on the construction and function of hospitals. He provided the trustees not only with a plan that would make the new hospital uniquely effective for medical teaching and research as well as the care of patients but also provided much of the educational scheme that the medical school would later adopt. One of his plans called for each of the highly selected medical school classes to be limited to twenty-five members and, that, during the fourth year, they should live on the third floor of the Administration Building. In this respect, at least, Billings's advice was ignored. The classes became larger than twenty-five, and the fourth-year class did not live in his grand construction.

Flanking the Administration Building—named for Billings in 1976—were two structures with similar exterior appointments for paying patients. Stretching west to east on the north side of the lot were five less ornately designed public ward buildings connected by the "Long Corridor," which extended for a quarter of a mile between the buildings facing Broadway and the "Isolating Ward" on the east.[14] The corridor still exists although none of the buildings it now connects were designed by Billings.

Although medical faculty had joined the university in 1885 to teach physicians and undergraduates, the first class of medical students did not begin their studies until eight years later, four years after the hospital opened. During this interlude between the opening of the hospital and the medical school occurred one of the first controversies between Hopkins's two creations. The hospital proposed teaching courses to graduate physicians, a scheme that greatly con-

cerned Daniel Coit Gilman, the university's first president. Gilman wrote a long letter on October 11, 1889, reminding the hospital trustees that "all that belongs to medical instruction should be under the control of the University; all that belongs to the care of the sick and suffering . . . belongs to the Hospital."[15] Despite the president's objections, the hospital offered the classes for several years until the school opened. With the hospital wards then needed to teach the medical students, the hospital gradually abandoned the project.

The story has often been told of how a group of young women, all close friends and each a daughter of a trustee of the university, offered to help develop the funds needed to open the school since the value of the dividends from the Baltimore and Ohio stock in the university's endowment had greatly decreased.* Their support depended upon the school's admitting women on the same basis as men, against the policy of the university at the time. The women also stipulated that the university only select students with bachelor's degrees or equivalent courses of study and that the medical curriculum take four years.† The women's provisions so distressed Gilman that, as one of them wrote, he "used every unfair device—and he had many in his bag of tricks—to persuade the trustees to refuse this $100,000."[18] Gilman eventually relented, however, and in October 1893, fifteen men and three women enrolled as the first class of the Johns Hopkins University School of Medicine.‡

The dual corporate structure continued as the school and hospital developed into the model for similar institutions, many of which came to be populated and led by Hopkins-trained doctors. Gilman briefly served as president of the hospital from May to August 1889 until the hospital board appointed Dr. Henry Hurd as superintendent and the first of a series of physicians to lead the hospital.[20,21]

* Hopkins had endowed the university with his stock in the Baltimore and Ohio Railroad, which he "recommended" that the university trustees not sell, and Clifton, his county estate of 330 acres.[9] The hospital received his bank stocks and most of the remainder of his real estate,[16] including the land on which the hospital would be built.

† Osler told William H. Welch, the dean and professor of pathology, "We are lucky to get in as professors, for I am sure that neither you nor I could get in as students."[17] As for the four-year plan of instruction, the medical schools at Harvard, Michigan, and Pennsylvania had recently adopted this curriculum.

‡ A provision of the gift specified that if Hopkins ever broached any feature of the agreement by which the women's fund came to the medical school, the money would be transferred to Bryn Mawr College. Dr. Richard Johns, the longtime director of the department of biomedical engineering, remembers how, when he was admitted to the medical school during World War II without a bachelor's degree, Bryn Mawr was asked, and agreed, to allow this to happen without demanding transfer of the endowment.[19]

Until the 1920s, the influence of Dr. William Welch, the first professor of pathology and dean of the school of medicine, "held the ship together," as Dr. Thomas Turner, Welch's successor as the eighth dean (1957–1968), writes.[22] Thereafter, several presidents of the university and the hospital, trustees on both boards, and faculty leaders would try to improve on Johns Hopkins's dual governance invention. None would succeed until 1996.

In 1923, university president Frank Goodnow proposed to the hospital trustees one of three solutions to the problems raised by the governance structure:[23]

— Merge the two corporations
— Interlock the boards of trustees
— Define by contract the fiscal responsibilities of each corporation

The hospital trustees rejected the first two of Goodnow's suggestions but did agree to allow the hospital or university to construct buildings on the other's property and to participate in a mechanism to divide annual operating expenses between the two entities.

About thirty years later Hopkins made a serious attempt to combine the several Johns Hopkins Medical Institutions under Dr. Barry Wood,[24] who, after training at Hopkins, had become chairman of the department of medicine at the Washington University School of Medicine in St. Louis. Hopkins brought Wood back as vice-president of the Johns Hopkins Medical Institutions[25] to bring the components of the medical institutions closer to their parent university.[26] Wood found the position a "nonjob," as Dr. Richard Johns remembers the post's lack of authority.[27] Wood resigned the vice-presidency, and Hopkins appointed him director of the department of microbiology.[24] "It was an extra layer of administration we didn't need," remembers Dr. Vernon Mountcastle, the renowned Hopkins neuroscientist.[28]

In 1971, Dr. R. E. Gibson, the director of the Johns Hopkins Applied Physics Laboratory, and Richard Johns* prepared a "Study of the Management of the Johns Hopkins Medical School and Johns Hopkins Hospital" at the request of the dean and the hospital director.[29] Although more involved with internal reforms in the school and hospital, the paper also raised the possibility, about which no action was taken, of combining the two boards into one with the creation of a chancellor to whom the dean and the director would report.[29]

* Richard Johns, like Johns Hopkins to whose family he was not directly related, also descended from immigrants from Cornwall, England.[5]

Two Boards of Trustees

> If you want to know who's powerful in Baltimore, the best place to start is the board of trustees at the Johns Hopkins Hospital. It is almost certainly Baltimore's most exclusive club.

So proclaimed the *Baltimore Sun* in 1991 in an article describing the leading citizens who directed one of Baltimore's premier not-for-profit institutions.[30] Beginning with the initial choices of Johns Hopkins, most of the trustees of the Johns Hopkins Hospital have been Baltimore residents exercising relatively close control of hospital activities and plans[5] and functioning in a clublike manner.[31] Traditionally, the members had been community leaders, such as the presidents of the largest banks and corporations,[32] eminent lawyers, philanthropists, and at least one clinician from the hospital. As the 1990s began, three of the twenty-six trustees were women. Only one was black in a city that was predominately black, and the membership included no residents of the depressed neighborhood in which the hospital operated.[30]

For decades, successive executives of the Mercantile Safe Deposit and Trust Company, which managed the trusts of many wealthy Baltimoreans, chaired the hospital board.[5] In the 1990s alone, two of the three hospital board chairmen were senior executives of the Mercantile: Furlong Baldwin, chairman and CEO for twenty years,* and Edward ("Eddie") Dunn, president of the Mercantile and its parent, Mercantile Bankshares, during that decade. The style of operating as well as the membership of the university and hospital board differed. The medical school dean's office, according to Richard Ross, the dean from 1975 to 1990, saw the hospital board as "small, proactive, and hands on," while the university board was "big, diffuse, and, by and large, oriented toward the [nonmedical] departments."[33]

"The hospital's a business and the university's less capitalistic and less disciplined" is the way Michael Bloomberg, when he was chairman of the university board, described an important difference between the two enterprises.[34] The members of the hospital board involved themselves more

* Baldwin, born at the Hopkins Hospital and raised on the eastern shore of Virginia, attended the Gilman School, a leading Baltimore private school for boys, and Princeton (class of 1954), a sequence which, in the case for doctors from Baltimore, was often followed by the medical school at Hopkins. Baldwin's sport, as befits a Baltimore athlete, is lacrosse, and he was a Marine.

than did the university trustees in the day-to-day activities of their charges. Hospital trustees, who were professionally expert through their jobs in such fields as corporate law, debt financing, insurance, investments, and pension funds, regularly advised and guided the hospital executives in these areas.[35] This activity helps to explain the comment of Andre Brewster, hospital board chairman in the 1980s: "I saw it as a business board, not a charitable board." In contrast, Brewster sees the university board, on which he also serves, as "a charitable board. We sit in a big amphitheatre, hear a bunch of speeches, and have little to say or do unless we have a specific point to make."[36]

The university board of about fifty term members plus a similar number of emeritus members is too large to conduct the day-to-day business of the university.[37] This is done by an executive committee of about fifteen trustees.[38] The size of the hospital board had grown over the years from the original twelve members in the nineteenth century to about thirty-five by the mid-1990s.[39] Most trustees attended each quarterly meeting, easier for them because most lived in the Baltimore area than for the more diversely distributed university trustees. A smaller executive committee of about twelve, vigorously led in the first half of the 1990s by Furlong Baldwin, met monthly and developed the policies for the hospital.

The membership as well as the size of the two boards differed.[34,40,41] Although many of the members of the university board held Hopkins degrees, increasingly, they were not Baltimore or Maryland residents;[40] several had national reputations.[41] Although most of the hospital trustees were local residents, a reasonable arrangement since the hospital principally served local patients, many had been undergraduates at colleges and universities other than Hopkins.[40]

With the tradition of active participation in their charge,[32,35,37,42] the hospital trustees tended to think of the university trustees as "advisers of the president and not much aware of operating detail," according to a longtime observer of Hopkins politics.[5] Former hospital board chairman William McGuirk and his fellow hospital trustees saw the university trustees as "more ivory tower, with lawyers and social types from Baltimore and Maryland,"[32] providing a "more passive, oversight review."[35] Former chairman of the university trustees Morris Offit understands. "They [the hospital trustees] saw us [the university trustees] as nonbusinesspeople."[43]

At the Homewood campus, north of the center of the city,* home of the students and faculty of the school of arts and sciences and engineering, the university officers and trustees thought of the hospital board as insular and the trustees as local businessmen without much vision. University partisans saw the *U.S News & World Report* ranking of the Hopkins Hospital as number 1 based primarily on the quality of the faculty and believed that the hospital trustees never grasped the fact that, without the medical school, the Johns Hopkins Hospital was no more than a general hospital in a poor part of town.[31] "The chiefs and the faculty are the guts of the institution," said Offit. "You're only as good as your faculty."[43] University officers deplored what they saw as the belief of some hospital trustees that the fame of their institution depended more on the facilities and the services than on the contributions of the faculty.[44]

The chairman of the university trustees, the university president, and the dean of the school of medicine served on the hospital and health system boards ex officio.[45]† This, to some extent, tended to compensate for the decreased overlapping of trustees on both boards since the founding, when nine of the twelve hospital trustees were also trustees of the university. Concurrent membership on both boards had decreased since the founding so that by 1923, only three served on both the university and hospital boards.[22] By the 1990s, about 40 percent of the hospital trustees were also university trustees.[46] "Only the name was the same," said Morris Offit. "Two different cultures had developed."[43]

Life in the academic world could amaze the hospital trustees. "Business and legal people like me can greatly underestimate the power of academia," Andre Brewster observed. "We announce a decision. The next day, a petition from the local geniuses appears on your desk objecting. It is so hard to make business sense of academia."[36]

Membership on the boards of the Johns Hopkins Hospital and Health System continues to be a mark of high distinction in Baltimore. "There is almost a religious quality about it," one observer has said. Chairing the board,

* The medical institutions including the hospital remain where Johns Hopkins sited them, in East Baltimore, three-and-a-half miles southeast of Homewood and, for many decades, an economically depressed section of the city.

† The Johns Hopkins Health System, incorporated in 1986, includes the Johns Hopkins Hospital and its many associated organizations but not the school of medicine (see below). The membership of the hospital and the health system boards was, until recently, identical.

however, is not a sinecure. Baldwin estimates that he spent ten to twelve hours per week on hospital business while he was chairman,[42] and Andre Brewster one-quarter of his time. "I was part of it and I loved it," says Brewster. "The most constructive thing I ever did."[36]

The Muller Years

"One of my big disappointments," says political scientist Steven Muller, president of the Johns Hopkins University from 1972 to 1990, "was not institutionalizing single leadership for the two institutions."[47] Even after his presidency ended, Muller continued to wish that he could have found a suitable formula to bring the hospital and the university closer together governmentally without combining the boards of the two institutions. "Although not a slave of history, I didn't want to go against Hopkins's will. It's hard to break out of the historic bond, and joint governance is part of the legacy."[47]

Although never achieving formal consolidation, Muller had temporarily returned to the early Gilman days, when the same man served as president of both the university and the hospital. When Muller arrived at Hopkins from Cornell University, both the university and the hospital were about to start separate fund-raising campaigns. This made no sense to Muller, part of whose last job at Cornell had been supervising the university's development programs. In the process of resolving the problem at Hopkins, the hospital board asked him to become president of the hospital.[47] He agreed to do so if he could name his own hospital director. Acknowledging that "I knew nothing about running a hospital,"[47] Muller did not intend to manage the day-to-day operations of the Johns Hopkins Hospital in addition to leading the university, but he wanted his own man as the senior hospital executive. He appointed Hopkins faculty member Dr. Robert Heyssel as executive vice-president, but continued to participate actively in hospital affairs in addition to chairing the monthly meetings of the Advisory Board of the Medical Faculty, the senior academic committee of the medical school.

Although Muller resigned the hospital presidency in 1983 with Heyssel replacing him, no permanent change in the governance came about despite several efforts before and during Muller's presidency. The impetus for such endeavors derived from chronic conflict between the two institutions. "There was a real split between the hospital and the medical school," Dr. Guy McKhann remembered when he arrived from Stanford in 1969 as the first director

of the department of neurology.* "They'd rather screw each other than survive" was the modus operandi on the East Baltimore campus. "We could play one off against the other."[48] Other senior academic leaders[49] and hospital trustees[32] recognized this also. "The chiefs were autonomous," says William McGuirk. "They took refuge in the university or the hospital when they had trouble with the other."[32]

In the early 1980s, a consultant retained by the university and the hospital suggested creating a holding company to include both entities. Heyssel and his board opposed such a change. "That wasn't the problem," Heyssel remembers. "The problems involved East Baltimore only," he said, referring to difficulties in governance between the hospital and the school of medicine and not between the hospital and the central university at Homewood. "Creating the new structure would only have increased the overhead."[50]

Later during the 1980s, several board members and the dean tried to develop a unified scheme. Andre Brewster, chairman of the hospital board and a joint university trustee at the time, proposed an arrangement from the viewpoint of his profession of corporate law. "I believed there had to be a single person in charge, and it had to be a university type even though I'm from the hospital."[36] He knew that the university was the larger organization and, most important, the university, not the hospital, owned the medical school.[36]

Brewster suggested creating the position of chancellor over both the university and the hospital, with the chancellor's office in a holding company structure, where the university and the hospital were subsidiaries. He also presumed that the chancellor might, at least at the beginning, also hold the title of president of the university. As for the trustees of the holding company, "I wanted a board that represented both institutions, perhaps a group of joint trustees, including the university president, the dean, and the hospital CEO. This board would control the appointment and discharge of the chancellor."[36] Although Heyssel, Muller, and the trustee who was chairman of the university board at the time liked the plan, "three points, each with some validity, helped to kill it," Brewster remembered.[36]

— The dean of the medical school would not accept standing below the hospital, for, in the proposed structure, the school reported to the

* The leaders of the departments at Hopkins are called "directors," not "chairmen" or "chairs," as is the custom at most other medical schools.

university president whereas the hospital's CEO reported directly to the chancellor.[51]

— The university would not accept giving the members of the hospital board an equal voice in selecting the chancellor.

— The hospital board would not accept the university's having a superior position over the hospital. "Didn't want second-class citizenship," said George Bunting, Furlong Baldwin's successor as chairman of the hospital board in the 1990s. "Several of the hospital trustees were concerned that university considerations might take precedence over patient care."[52] Others were afraid of giving someone so much power.[53]

In the year before he retired, dean Ross proposed a similar plan. In the document, "Governance of the Johns Hopkins Medical Institutions,"[11,54] Ross suggested that the medical school, in effect, leave the university and become part of a new corporation named "The Johns Hopkins Medical Institutions."* This entity would appoint a president to whom the dean of the school of medicine and the president of the hospital would report. In time, Ross suggested, the other institutions on the East Baltimore campus, the schools of hygiene and public health and of nursing, might be brought into the Johns Hopkins Medical Institutions corporation.[56] "Muller and I were retiring," remembers Ross. "It seemed like an ideal time for a change."[56,57]

Ross's reasons for loosening, or preferably separating, the ties to the university were primarily financial and will be easily understood by all medical school deans. According to the university's "general formula," the overhead expenses of the central university are assigned in proportion to the expenses of each of the schools. Since the school of medicine generates half of the expenses, it pays half of the overhead. Furthermore, the university, not the school where the money is generated, retains, in its "temporary investment pool" (TIP), the interest produced by funds collected from the granting agencies and not as yet spent by the investigators. The school of medicine generated 75 percent of the money in the TIP in Ross's day.[56,57] Ross also objected to funding half of the central university's development expenses when the school of medicine, in

* The name Johns Hopkins Medical Institutions is an unofficial phrase used for decades, but less often recently, to identify the schools and hospital on the East Baltimore campus. Edward Halle, former senior vice-president at the hospital, thinks it originated in the 1970s, but its provenance and its author are unknown. Robert Heyssel, the former hospital president, called it "a term of convenience."[55] By 2002, however, "jhmi.edu" remained the domain of the e-mail addresses used by most of the hospital and school staff in East Baltimore.

association with the hospital, paid separately to raise money for the institutions on the medical campus.

Muller had actively participated in helping to raise large contributions to rebuild much of the hospital, which had been allowed to age, adding new construction for the medical school and expanding the other professional and graduate schools as well. By 1987–1988, with stock market values falling severely, the university trustees objected to spending endowment for the president's new initiatives. The investments in arts and sciences,[41] among other projects, had shaken Hopkins's finances.

To repair the university's finances, Muller[31,41] "secured the commitment of the university's schools and centers for a one-time tax," as Muller's provost at the time, John Lombardi, describes the process.[58] Since the medical school was the richest, its assignment, as the people at the medical school saw the tax, or "share" (the word Lombardi favors),[59] was the largest, $20 million paid over five years,[56,57] representing about 80 percent of the total the university assessed its schools.[41] The levy particularly angered Ross and his colleagues[56,57] and increased the dean's antipathy for the president.[31]

Muller, however, looked on a large contribution from the medical school as appropriate. "They were very flush at the time," he remembers.[47] Muller, however, did not try to tax the hospital since "you don't need to have a school of arts and sciences to be a hospital," whereas a first-class university with a medical school must include arts and sciences.[47] Furthermore, the separate hospital board would certainly have opposed being taxed, an option not available to Ross, who reported to Muller and had no board of his own as did Heyssel to fight his battles with him.[45*] The tax, moreover, gave substance to the anxiety of some of the hospital trustees about what might happen to hospital money if the university controlled the hospital. Ross speculates, "If this had not happened, it might have been possible to bring about some closer relationship even sooner."[56]

Ross had been "squirreling away," as he put it, "about $10 million for my successor"[56] from surpluses in the school's faculty practice plan. As is the case at most medical schools, the dean retained a portion—10 percent at Hopkins—

* When the title of the senior executive of the hospital changed from "director" to "president" in 1963, the incumbent began dealing directly with the president of the university, to the irritation of the dean of the school of medicine at the time who complained that he was being left "out of the loop." As Richard Ross remembers the episode, the hospital director told the dean "presidents talk only to presidents."[45] Later, when Heyssel became hospital president during Ross's term as dean, Ross "called this lack of parity in titles to Muller's attention but got nowhere."[45]

of the funds collected from the full-time doctors' professional fees for investment at his discretion in the medical school. "The faculty trusted that I would spend the money wisely," said Ross, "so when the university took the funds, they felt 'our money is being stolen.' "[56] Most members of the medical faculty had little sympathy for Muller's financial problems and slight inclination to "bail out the university," as one observer summarized the mood on the East Baltimore campus.[60] Many of the faculty had received their undergraduate degrees at other colleges and universities and had few ties to Homewood, where the arts and sciences departments were located. Feelings at the medical school became so heated that the Advisory Board of the Medical Faculty voted no confidence in Muller.[56] The objections from East Baltimore, however, had little substantive effect, and, pursuant to Muller's instructions, the medical school transferred $20 million to Homewood during the next five years.

Ross's plan to separate the school from direct control by the university never had a chance of being adopted even though some university trustees favorable to the medical school understood where Ross was going.[5] The university strongly opposed untying itself from its medical school, whose fame was so great that many thought of Hopkins as primarily a medical institution.* Furthermore, Homewood could never afford losing the support for nonmedical expenses at the university, which the medical school, albeit begrudgingly, supplied.

To Ross's surprise, the Johns Hopkins Hospital also opposed his plan. Leading hospital trustees feared that including the medical school in its corporation would somehow bring interference from the university in hospital affairs since complete separation from the university seemed unlikely.[56,57] Baldwin told Ross, "University presidents are not businessmen. Muller opened up a deficit and look what he did to you."[42] Although he was also a member of the university board, "Baldy's [Baldwin's universally employed nickname] heart was in the hospital," Ross knew.[56,57] Baldwin recognized, however, that "the school was an integral part of the hospital's functioning."[46] Despite his bias toward the hospital, Baldwin supported Ross's objections. "I was on Dick's side over Steve's tax," he said.[42]† The tax also made allies of Heyssel and Ross since the

* Senior faculty member Guy McKhann remembers Milton Eisenhower paraphrasing Winston Churchill, "I wasn't named president of Johns Hopkins University [1956–1967] to preside over the breakup of its medical center."[48]

† "Our only bragging rights here is Hopkins," says Baldwin. When asked where would Baltimore be without the Hopkins university and hospital, he answers, "Trenton."[42]

school would need to ask the hospital to help make up the loss produced by the university's tax.[42]

Although the university succeeded in extracting the tax, the medical school's strong resistance contributed to Muller's decision to retire from the presidency in 1990.[47] Described by some of his severest critics in East Baltimore as very articulate and intelligent and a quick thinker, Steven Muller had not been at his best during the final years of his presidency. "His tenure was eighteen years," observed one of his trustees. "He gave us fifteen magnificent years."

Muller established his new office in the Hopkins School of Advanced International Studies (SAIS) in Washington, D.C., thereby distancing himself from the location of his previous responsibilities. Not for the first time had a university president found the medical school and university hospital a potent determinant of his professional plans.

Heyssel versus Ross

When Michael Johns became the twelfth dean of the Johns Hopkins University School of Medicine in 1990, the leader of the Johns Hopkins Hospital and Health System was Robert Heyssel, senior to Johns in both tenure and experience. In two years, however, Heyssel would retire after twenty years as CEO. Although Heyssel, "the bulldog" in the eyes of one observer, and Ross, "the terrier," argued mightily in their time, the intensity of their conflict never approached the passion or led to the consequences of the discord between Block and Johns.[5,43,47,61-66]

Although they battled continuously on behalf of their charges, Heyssel and Ross were deeply committed to both institutions and made their decisions based on what was good for Hopkins's academics. This would be expected from the dean, but was also the case for the hospital president. Heyssel had been a medical school faculty member and had conducted research. Their arguments centered more on money than fundamental principles, upon which they basically agreed. Even faculty members strongly oriented to the school of medicine agreed that Heyssel, although a tough man to bargain with, used ethical methods and had honorable aims.

Neither Heyssel nor Ross wanted to put their jobs together. Both felt that the differences in the missions of the school and hospital needed separation, and that each would only be successful if he came from a different starting point. Each led his end of the business well and "didn't run off and do some-

thing alone." Nevertheless, Heyssel, supported by what Ross refers to as his "strong, proactive board," continuously struggled with the school of medicine and the university for power. "I used to counter," recalls Ross, "by quoting the founder's statement that he hoped, in due course, the hospital would become part of the university. Bob hated to hear that quote."[45] After their debating was over, however, they reached good compromises. Although Heyssel sought counsel from his trustees, he never took his differences with Ross into the boardroom.

The Heyssel–Ross relationship flourished during the more prosperous 1980s, a more forgiving time[67] in hospital financing when the dean felt more comfortable leaving clinical matters to the hospital.[67] "The hospital's pockets were deeper," explains Levi Watkins, a cardiac surgeon and associate dean, so "the men were secure in their roles and financial security bred happier times."[63] Watkins acknowledges, however, that "they had powerful egos. Bob was not timid in his approach to administration and to the chairs."*

The academic backgrounds of the future dean (1975–1990) of the school of medicine and the senior executive (1972–1992) at the hospital differed. Both grew up in the Midwest, Ross in Indiana, Heyssel in Missouri, but, after youth, their lives took separate paths. Ross received his B.A. and M.D. degrees from Harvard, and then, except for two years in the army, spent the rest of his career at Hopkins, becoming chief of cardiology in 1961 at the age of 37 and dean fourteen years later. Although seen as controlling and patrician by some, most found Ross "a warm people person and a good recruiter." His working style was deliberate and conservative, and he was disinclined to make quick, impulsive decisions. Although he could be strong-willed, Ross never wanted to insult anyone, was very politic,[68] "hated public clashes,"[31] and reacted to stress with equanimity.[31,69] "Ross never said bad things about Heyssel," observed Patrick Walsh, the director of the department of urology. "I think he could have worked with anyone, even with Satan."[69]

Although the former chief of a clinical division, Ross was "the best champion of basic science," according to Solomon Snyder, director of the department of neurosciences.[70,71]† "He recruited good chairs and allocated the

* As a junior faculty member at Vanderbilt University medical school, Heyssel had befriended Watkins when "I was by myself" as the first African American student there.[63] Later, when associate dean for postdoctoral affairs at Hopkins, Watkins would champion giving paternity leave for the house-staff and fellows, a change in the intense training schedules for which Hopkins was renowned. Heyssel approved the plan, "to the amazement of many."[63]

† Hopkins has eight basic science departments: biological chemistry; biomedical engineering; biophysics and biophysical chemistry; cell biology (the successor to anatomy); molecular biology and

money successfully. What we have now, we owe to him."[71] One of the senior trustees goes further. "With commanding integrity, Ross completely revitalized Hopkins medicine through the research mission," believes Morris Offit, a Hopkins alumnus (B.A. 1957), member of the university board during most of the Ross years, and board chairman later (1990–1996).[43,72] Moreover, Ross was a man of his time. "Dick was old-line business, not e-commerce," one of his closest colleagues said.[5]

Heyssel stayed closer to home, receiving his bachelor's degree at the University of Missouri and his M.D. at St. Louis University. Trained in hematology and nuclear medicine, he joined the faculty at Vanderbilt University in Nashville and came to Hopkins in 1968 to direct the outpatient activities when Dr. David Rogers was recruited from there to be dean. When Rogers left three years later, Muller, as president of both the university and the hospital, chose Heyssel as his on-site hospital director. Muller, seen at the medical school as a strong university president, recognized in Heyssel similar characteristics that would benefit the hospital. "I had gotten to know Muller when he was provost," Heyssel remembers. "So when Steve became president, he appointed me."* Admitting his lack of experience in hospital administration, Heyssel adds, "I probably wouldn't have chosen me."[50]

While also president of the hospital, Muller met weekly with Heyssel and Ross.[56,57] The dean, concluded one of the department directors, "was caught in the cross fire between two people stronger than he both in the offices they held and in their natures. Besides, Muller could not moderate successfully between Dick and Bob. He wasn't a doc and never got along with Ross."[48]

In 1983, partially in response to continuing efforts by other institutions to recruit Heyssel, Muller agreed to resign the hospital presidency in his favor. Heyssel now had the autonomy he wanted and reported directly to the hospital board rather than through Muller, unlike Ross, who continued to report to the university president and not to a board of trustees.[43]

"Dick was livid when Muller stepped down as the hospital president be-

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genetics (formerly microbiology); neuroscience; pharmacology; and physiology. There are about 200 members of the basic science faculty at Hopkins, the typical size of each basic science department being ten to twenty primarily appointed members. One large clinical department may have more members than all the basic science departments together.[71] Pathology, considered a basic science in many medical schools, has more of the attributes, in size and function, of a clinical department at Hopkins. Its offices and laboratories are in hospital rather than medical school buildings, and the department has more than 100 faculty members on its roster of primary appointments.[70]

* "Steve and I were close," according to Heyssel. "We talked all the time. I never blindsided him."[55] Heyssel once said about Muller, a superb public speaker, "he spoke in soliloquies."[36]

cause Muller was his cover," remembers Offit.[43] "The hospital trustees didn't want the university president over them. They didn't need an academic telling them what to do."[43] While the change annoyed the dean, Muller's resignation as hospital president pleased the hospital trustees, many of whom wanted the hospital to keep its distance from the university. "Steve would show up at our meetings with his staff, his praetorian guard, and his own agenda," said one. Muller had held the hospital presidency, it was said, so that the hospital would subsidize part of his salary.

"Bob was a real CEO-type person in contrast with previous people who had directed the hospital," observed Mark Rogers, former director of the department of anesthesiology and critical care medicine and now CEO of a medical investment company.[73] Because he was the product of a Midwestern education, "the Ivies around him [many of the doctors at Hopkins had attended or trained at elite eastern institutions] didn't impress him," his good friend, Paul McHugh, director of the department of psychiatry, said about Heyssel. "What counted was what you could do for Hopkins."[74]

"Bob looked like a country bumpkin when he started," his longtime associate Edward Halle remembered, "but when he moved into what he called the front office," he grew into the job rapidly,[63] became a very astute businessman,[64] and soon "looked like he'd been president of General Motors for years."[75] Compared with Ross, "a milder facilitator," in the view of Irvin Kues, longtime chief financial officer at the hospital, Heyssel was "a strong leader who could influence the chiefs with his personality and background and experience cajoling people."[65]

A tall man, "colossal in size," McHugh described Heyssel at his memorial service.[74,76,77*] "He ran the hospital extremely well, but he could be a grouchy old bear," Baldwin said.[46] "A barking dog," according to Hopkins's renowned urologist Patrick Walsh,[69] "the epitome of gruff," said McHugh, using the adjective many of those who knew him used to describe Heyssel. Some criticized his bullying style. Called a "gunslinger,"[69] Heyssel expected direct answers to his questions.[74] If not, his reply would be "muscular," more specifi-

* An inveterate cigarette smoker, Heyssel died from lung cancer and emphysema on June 13, 2001, at the age of 72.[77] The service was held in Hurd Hall, a large auditorium in the hospital named for Dr. Henry Hurd, the first superintendent of the Johns Hopkins Hospital, who served from 1889 to 1911. Beginning in 1920, the title of "superintendent" for the chief executive of the hospital was changed to "director," a title that the successors to Hurd, beginning in 1920, employed until 1983, the year Robert Heyssel succeeded Steven Muller as hospital president. The title "president," was first used by Dr. Russell Nelson, Muller's predecessor as head of the hospital, in 1963.[20,21]

cally, "profane."[78] Prolonged laughter by those at the service followed Heyssel's being described as "opinionated,"[75] a fundamental feature of his character.

Senior cardiologist Stephen Achuff, who, like Heyssel, grew up in Missouri and attended the University of Missouri School of Medicine, saw him as the "most forceful" of the three senior executives involved in Hopkins medicine at the time: university president Steven Muller, medical school dean Richard Ross, and Heyssel.[78] "He ran a very tight ship, was tough to deal with, and didn't take criticism well."[78] Heyssel clearly "went his own way," observed Walsh. "The faculty found out what was happening by reading about it in the newspaper."[69] "Bob was a leader who enjoyed a good confrontation," observed Edward Dunn, a leading hospital trustee, "but everyone knew his mission was doing what was best for Hopkins, not for himself."[35]

The hospital's administration, throughout Heyssel's time, felt that the medical school should deal with its traditional responsibilities and not interfere in hospital matters. "If the hospital were run by the medical school, we'd be in chapter 11," Edward Halle remembers most of the hospital's administrative officers thinking. "They aren't businessmen. We kept them in line with the famous initials ABNF, 'approved but not funded'."[11]

Heyssel forced the medical school to construct its Ross Building, named for the former dean, over Rutland Avenue at increased expense because the block to the east, where the school wanted to site the building, was owned by the hospital. "No way Bob would let the medical school build a large research building on his turf," said Richard Johns.[5] Heyssel's view of himself coincided with what many were forced to acknowledge: "I'm tough, not rigid."[50]

A visionary—"ten years ahead of his time," as many portrayed him—Heyssel could see that managed care was coming long before it appeared. Unlike what others might have predicted, he became deeply involved in assisting the citizens of the economically deprived area surrounding Hopkins to receive better care from the elite institution in their midst. "He worked with us when we thought Hopkins never would," a leader from the local community remembered.

The Hopkins Hospital Rebuilds

When Robert Heyssel became the executive vice-president and director of the hospital in 1972, he inherited the management of a famous institution, which cared for about 700 inpatients each day and which had severe

financial and physical problems. The hospital was losing between $2 and $3 million per year, not a trivial amount in the early 1970s.[65] The plant was so decrepit that several well-known physicians and surgeons from elsewhere, when offered senior positions at Hopkins, refused "because the facilities were so bad," Heyssel remembered.[50] With many of the patients having no insurance or other means of paying for their care, the hospital had never earned a surplus on operations from the day it opened, the deficits made up each year by contributions from wealthy trustees.[50] The losses had even required spending from the endowment, "eating our own corn," as Heyssel called the practice.[50]

With the trustees estimating that the hospital needed to spend $100 million for new buildings and renovations, Heyssel had to produce a profit. To increase income, Heyssel successfully convinced the Health Services Cost Review Commission (HSCRC), the recently established agency that regulated hospital charges in Maryland, to raise the rates Hopkins could charge.[50] To reduce expenses, he decreased the size of the hospital staff and improved efficiency through his novel decentralization program (see below). To develop funding for capital improvements, he borrowed money, which previous administrators had avoided doing.[50] Heyssel convinced, in some cases forced, the chairmen to understand that the bed allocations had to be rationalized. "I've got eighty beds, 50 percent occupied. I still need eighty," was a typical response when Heyssel came calling.[50] By 1977, the hospital had begun to generate a surplus.[65]

During the next ten years, the hospital built a new patient tower for medical and surgical patients, an oncology (cancer) center, a new building for the psychiatry, neurology, and neurosurgery services, a radiology department, and a new reception and admitting area. As older structures were demolished, those considered worth saving were renovated.

The hospital's financial status continued to improve as the new buildings helped to attract more private patients, the administration produced greater efficiency, and the HSCRC supported the cost of caring for patients without adequate resources of their own.[65] Heyssel knew, however, that one important function remained severely underdeveloped. The outpatient facilities were primitive, scattered throughout the campus, and inconvenient to patients as well as the doctors. The hospital president would solve this problem toward the end of his tenure.

A "Department-Centric" System

While William McGuirk was chairman of the hospital board during the 1970s, the consultant Richard Beaumont examined the organization of the Johns Hopkins Hospital.[72,79] As a result of the consultation and a previous study by faculty member Richard Johns and colleague,[29] Heyssel developed a unique decentralized system of management that delegated authority over resources to the clinical departments.[12] The new structure significantly reduced the amount of administration performed by the hospital's central departments.[80]

Each clinical director became a functional unit director (FUD) to whom the hospital delegated the administration of the inpatient and outpatient units in which the medical work of the departments was conducted, thereby, in each case, administering "a hospital within the hospital."[81]* To keep track of the hospital dollars administered by the FUDs, Heyssel assigned nonphysician managers to hold the directors to their budgets.[11] In recognition of their responsibility as FUDs, the hospital pays half of the salaries of the department directors[11] and participates with the school of medicine in evaluating their performance as managers.[66] Nevertheless, the clinical chiefs look to the dean, not the hospital director, as their paramount boss.[69]†

Whereas Hopkins seems to specialize in decentralization, this approach means that its clinical departments and divisions must succeed, to a great extent, on their own, and, accordingly, the power of the department directors has grown.[53,70] Former hospital board chairman Furlong Baldwin calls the department directors "the merchant princes, the satraps of Hopkins."[42]

Heyssel's decentralization scheme has seldom been duplicated in other academic medical centers. "When people came to see us," Heyssel said, "nursing almost always opposed it"[55] since the nurses' bosses in both inpatient and outpatient units of each FUD were ultimately doctors who came to look on

* When one of the directors objected to the inelegant title of "FUD" for functional unit director, Heyssel suggested that the title could be changed to "functional unit chief."[50]

† Recruiting of directors of clinical departments, although conducted by the dean, also involved the hospital president, who presided over the facilities in which the new director would conduct the clinical parts of his job. In the Heyssel–Ross era, according to Heyssel, "Dick and I never had a battle over the candidates, although each of us could veto a choice if we thought it best." As for relieving a chief, Heyssel acknowledges, "I couldn't have fired someone unilaterally. Dick could."[50] When a conflict over a director arose between the dean and the president, Heyssel remembered, it was usually because the individual was academically qualified to lead the department but did not have the skills to be a successful chief of service in the hospital.[66]

them as "their nurses."[81] The scheme did not appeal to most nursing executives visiting Hopkins, who would typically complain, "Work for a doctor?"[55] When Heyssel introduced the system at Hopkins, the director of nursing opposed the system and left. Heyssel then recruited another director from Boston who agreed to administer nursing in the FUD era.[55] Under decentralization, the central nursing office concentrates upon setting professional standards and overseeing how the departmental nursing directors functioned, not on administering the day-to-day nursing care in the patient care units.

To some extent the FUD system is less easy to manage, further explaining why other academic medical centers did not adopt the system. "Decentralization leads to more negotiation and communication, a healthy situation," Irvin Kues explains, "although a little more aggravating."[65] Furthermore, most administrators, trained to operate in a centralized mode, may oppose the Heyssel scheme because they dislike delegating away their authority.[65] The FUD system tests the administrative abilities of the physician-directors of the clinical departments and divisions. Some, in Kues's experience, became "quite good at this. They understood everything when you let them grow but not when cuts were needed." He adds, "The system changed behavior but not attitudes."[65]

Decentralization does tend to slow the pace of decision making. This may have been helpful during the rapidly changing 1990s. Administrators have suggested that the characteristically sluggish process of deciding what to do, along with a lack of adequate capital, helped prevent Hopkins from making decisions, thought wise at the time, which would later prove unsound. "Although decision making may be slow here," says Ron Werthman, Kues's successor as chief financial officer for the hospital and health system, "when we're ready to move, we're ready."[81] Consequently, people say that "running," as in the question, "who runs Hopkins," does not really apply in East Baltimore since "this place is run by the faculty, not by any one person."[82]

Not all who come to Hopkins, particularly those who have worked in hospitals with highly centralized administrations, can adapt successfully to the routine. "It can take months or even years to understand the system and get comfortable with how decisions are made," says Werthman.[81] In summary, as one of the department directors who has worked at several other academic medical centers puts it, "This place is directed by physicians, not administrators. The loyalty is to us, to our patients, and to medical science, not to the hospital executives."[70]

Heyssel remained pleased with his creation. "Decentralization helped to make our cost system leaner than at most other places. We'd been too costly as they had been, as many still are."[50]

Johns Hopkins Bayview Medical Center

Like William Kelley at the University of Pennsylvania in the 1990s, Heyssel and Hopkins also acquired three hospitals, although a decade earlier. Only one merger would survive.

Built in 1773 "for the Relief of the Poor within the County of Baltimore," as the act establishing the Baltimore County Almshouse stated, this precursor of the Baltimore City Hospitals cared for those unable to care for themselves in medical facilities primitive even for the time.[83-85] In 1866, the City of Baltimore moved the almshouse to the Bayview section of the city on Eastern Avenue about three-and-a-half miles east of what would later become the Johns Hopkins medical campus.

By the end of the nineteenth century, the newly opened Hopkins medical school and the University of Maryland, which had trained local physicians since it was founded in 1807, began a professional association there which included the supervision of physician training and the appointment of faculty to provide medical care. As the almshouse developed into an institution with greater claim to be called a hospital, the trustees renamed it, in 1925, the Baltimore City Hospitals with acute and chronic facilities. Later, with the opening of a federal Veterans Administration Hospital elsewhere in the city, the two medical schools split their supervision of most of the services, with Hopkins paramount at Baltimore City and Maryland at the VA.

With the introduction of Medicare and Medicaid in the mid-1960s, the poor could attend other hospitals more readily, and the character of the hospital began to change. The city had prohibited the supervising physicians and surgeons from practicing privately, but now the doctors working there gained permission to create Chesapeake Physicians, their own practice group, and the Baltimore City Hospitals began to shed its municipal character.

This was the time when other city hospitals—the Philadelphia General Hospital was a relatively nearby example—were closing. The leaders of the Baltimore municipal government, frustrated with their increasingly expensive charge, would have closed City were it not for the resistance of the 1200 employees employed there and local voters, who thought of the place as their

community hospital despite its looking like a city hospital.[55] Alternatively, Baltimore could contract with other hospitals to manage City or sell it to whatever medical organization would buy it.[86] The fundamental problem, according to Dr. Philip Zieve, was that "the city bureaucracy didn't know how to run a hospital."[85] Zieve had spent most of his career at the hospital. After graduating from Maryland in 1958, he had served as a house officer there and in 1973 became chairman of City's department of medicine.

Robert Heyssel "recognized the value of the 130 acres[87] on which the hospital sat," Zieve remembers, "and believed that he could run two hospitals more cheaply than one."[85] In 1982, Heyssel dispatched Ronald Peterson, then administering the Hopkins Children's Center, to City to evaluate whether Hopkins should acquire it.[85*] For two years, Peterson and other administrators whom Heyssel had sent there managed the hospital under contract with the city and reduced its annual operating deficit from $7 million to $1 million.[55] Hopkins and the city decided that transferring ownership was a good idea, and on June 30, 1984, the Johns Hopkins Hospital acquired the former Baltimore Almshouse. The city even guaranteed, according to the memorandum of understanding between the institutions, that "if Hopkins determined that a hospital cannot be successfully operated at the BCH location, Hopkins has the right at the end of five years to reconvey the entire complex to the City at no cost to the City."[88] The mayor, then William Donald Schaefer, later the state's governor, and, more recently, comptroller, recognized that the city would continue to lose money operating the hospital itself because, for example, "the hospital had to use the city-owned laundry, which was expensive and inefficient," as one observer noted.[89] The decision to buy the hospital, however, did not please all in the medical school, including the dean.[55] "It's a dirty old city hospital," Mark Rogers, then director of the department of anesthesiology, remembers hearing colleagues complain.[73] "It was a risky decision," thought Steven Lipstein, one of Heyssel's acolytes in the Hopkins administration, "and would never have worked in an unregulated state."[64]

Hopkins named its new acquisition the "Francis Scott Key Medical Center." Zieve remembers that Steven Muller, the university president at the time, "didn't want the Hopkins name on it until it had proven to be successful."[85] By 1994, when its new inpatient building, partly funded by loans guaranteed by

* Peterson would later succeed the man who succeeded Heyssel as president of the Johns Hopkins Hospital.

the Johns Hopkins Health System and Hospital,[55] opened,[90] ridding the institution of the ambiance of a city hospital, the health system renamed it the "Johns Hopkins Bayview Medical Center."[91] The rechristened hospital, staffed for the most part by full-time members of the Hopkins faculty, had increasingly become a site for the training of Hopkins medical students and residents. Research programs on the campus flourished with the construction of new laboratory buildings.

"It's not a merger of equals," according to Dr. Reuven Pasternak, former president of Bayview Physicians, and now vice-dean for the Bayview campus.[92]* The directors and chiefs of the clinical departments at the medical school, advised by a strategic planning group from both hospitals, decide where specific, specialized clinical services will be based. By 2002, a musculoskeletal center and several important programs, including pulmonary medicine, allergy, ambulatory pediatrics, geriatrics, and substance abuse, were headquartered at Bayview.[92] Administratively, several departments at Bayview combined with the Johns Hopkins Hospital, including finance, general accounting, human relations, information systems, parking, planning and marketing, safety, and security.[62] Hopkins does not know, however, how much money has been saved by these consolidations.[62]

Johns Hopkins Bayview Physicians, the Bayview doctors' practice corporation, which had evolved from Chesapeake Physicians founded thirty years previously, was incorporated into the Clinical Practice Association (CPA), the Hopkins practice plan, in January 2002. Bayview Physicians had been losing money—slightly more than $3 million on total revenue of $74 million during 2000–2001[94]—and accumulating debt, partly because many of the Bayview patients held managed care contracts that paid the doctors poorly.[85] Furthermore, compared with the full-time faculty at the main Hopkins campus, fewer doctors at Bayview who were paid through the practice plan had grants to support part of their salaries. The Bayview unit did not have the administrative strength to maintain adequately the billing and compliance operations required by contemporary practice plans.[92]

Giving up the independence to operate their own practice plan caused "intense opposition" among some longtime physicians at Bayview, accord-

* "Merger of equals" was the mantra for the combinations of such teaching hospitals as the Massachusetts General and Brigham and Women's hospitals in Boston, New York and Presbyterian hospitals in New York City, and the short-lived union of the Stanford and UCSF hospitals in northern California.[93]

ing to Pasternak.[92] Hopkins tried to address the resistance by instituting the change slowly and supporting prolonged discussion and debate. "Everyone put his past grievances on the table," Pasternak remembered. "Rather than bridging the differences, it became a forum to air the differences. Finally, the people downtown ordered us to do it."[92] By 2002, consolidating the physician groups appeared to have produced annual savings of about $500,000.[92]

Wyman Park and North Charles Hospitals

In Wyman Park,* near the Hopkins Homewood campus, the United States Public Health Service had operated a hospital for several decades. The Department of Defense continued to contract for medical care there despite having given the hospital to a community board. About seventy salaried physicians, many of whom had Hopkins appointments, cared for the patients. Heyssel saw Wyman Park as an inexpensive place to hospitalize patients,[95] some of whom might have the severe and complicated illnesses particularly suitable for transfer to the Hopkins Hospital, and accordingly, he bought Wyman Park in the mid-1980s. At about the same time, the owners of the adjacent North Charles Hospital "approached me out of the blue," as Heyssel tells the story. "My first reaction was 'no,' but then I thought that, if we took it over, we could close beds in the old Wyman Park," which badly needed renovating, "and put the patients into North Charles," a small community hospital with newer facilities.[50]

Heyssel now had to accommodate the desires of two groups of doctors: the Wyman Park Medical Associates, a group practice that provided care for the Department of Defense patients, and the physicians who admitted patients to North Charles. When many who did not have Hopkins appointments requested them, the faculty at the school of medicine objected.[73] "Here I was," Heyssel remembers, "desecrating the Hopkins altar" with doctors whose qualifications would not have ordinarily fitted them for faculty appointments at one of the nation's leading schools of medicine.[50] Medical school dean Richard Ross confirms the conflict. "I'd hear about this sort of thing after it happened. Bob promised the docs they'd have Hopkins appointments without telling the

* William Wyman was one of the donors of the land where Hopkins built its Homewood campus. The original campus, where the nonmedical teaching was performed from the founding until about 1915, was downtown, a few blocks west of the square known as Mount Vernon with its monument to George Washington.

dean. I called it 'back door accreditation.' " This was a characteristic Heyssel performance, remembers Guy McKhann. "There was no discussion about North Charles. Bob just rode right over Dick."[48]

"Name dilution," as the wider use of the Hopkins faculty title came to be called, would plague the institution throughout the 1980s and 1990s whenever a school of medicine appointment was requested for doctors thought unqualified by former Hopkins standards. Those opposed to such ventures would quote the data from focus groups that did not perceive "Heyssel's docs" as "Hopkins docs."[96] Johns and Block would inherit this problem about who could use the Hopkins name.

As for North Charles, the hospital began to lose money not long after Hopkins acquired it, and Heyssel soon gave up the fight. "I decided it was a losing game. The world doesn't need a Wyman Park or a North Charles," he concluded, and sold North Charles to a company that owned nursing homes. Wyman Park was converted into an outpatient facility for a component of the Hopkins health system and an office building for the health system and the nearby university. These changes angered the Wyman Park doctors, but Heyssel arranged for them to admit patients to Hopkins and Francis Scott Key, and the turmoil gradually subsided.[50] The North Charles episode immunized Heyssel against making further hospital purchases.

Johns Hopkins Health System

As the Johns Hopkins Hospital's holdings grew with the acquisition of the former Baltimore City Hospitals, the trustees advised establishing a holding company to exercise corporate-level control over the two hospitals and future expansion. The new corporation, the Johns Hopkins Health System, created in 1986, became the sole member of the Hopkins and City hospitals.[97,98] The board of the health system, identical in membership to that of the Johns Hopkins Hospital until 1996, assumed the most important financial functions, such as borrowing money and selling assets, and left the hospital board with the operating responsibilities required by the state. The successors to the board of trustees that Johns Hopkins had established for his hospital more than a century previously continued to meet, but they did so at the same sitting before or after the meeting of the health system board.

Heyssel, now president and CEO of the health system, moved his office

from the historic Billings Administration Building,* where the hospital director had long worked, into renovated space in the Phipps Building, constructed early in the century for the department of psychiatry. Pressed by the board chairman, and against his own judgment,[55] Heyssel arranged that the director of one of most successful clinical departments be appointed to his old job as president of the Johns Hopkins Hospital. Heyssel envisioned the new president in the role of a chief operating officer of the hospital[65] and deferring to Heyssel. It did not work out that way. Assuming that he was actually supposed to run the hospital,[99] the new president started acting independently,[65] doing things his own way, not the Heyssel way. For example, the president decided to work with only seven department directors, several of them in charge of several traditionally separate clinical services. "These tensions played out at the chief of service level," according to Hamilton ("Chip") Moses, a neurologist who was Heyssel's vice-president for medical affairs from 1988 to 1993 and whom the new president wanted to run a combined hospital service of neurology, neurosurgery, and psychiatry.[66]

"It's him or me," Heyssel told his board, and the new president of the hospital stepped down.[55] Heyssel took back the presidency of the Johns Hopkins Hospital while continuing as CEO of the Johns Hopkins Health System. "I should never have allowed it to happen," Heyssel recognized. "The lesson learned was that the head of the Johns Hopkins Hospital and the Health System should be the same person."[55]

Heyssel continued his custom of not appointing a number 2. For a time in the 1980s, as many as thirty people reported to him.[66] "Bob didn't really believe in a chief operating officer," said Moses. Heyssel felt that "any teaching hospital should be run by individuals with functional control of clinical and administrative units." His system worked well, partly because Heyssel was a superb operations manager[100] and avoided micromanaging. "Bob didn't want his own hands on everything," in the opinion of Steve Lipstein, but "he did want to remain close to his principal executives and the clinical directors."[64]† Heyssel also did not favor planning directors—he was his own "chief planning officer

* Named for Dr. John Shaw Billings, who was retained by the hospital's founding trustees to design the original buildings.

† Lipstein left Hopkins in 1994 to become chief operating officer of the University of Chicago Hospitals. Since 2000, he has been president and CEO of BJC HealthCare, the St. Louis conglomerate that includes Barnes-Jewish Hospital, the principal teaching site for students at the medical school of Washington University.

and the architect of Hopkins strategy," according to Lipstein.[64] He once told one of his associates, "I do the planning in my head."[100]

Heyssel's successors have continued holding the positions of president of the Johns Hopkins Hospital and CEO of the health system concurrently, although they have appointed chief operating officers and planning directors.[100] Separate executives lead the other Hopkins-owned hospitals.

By 2002, the health system consisted of more than twenty partially or wholly owned corporations, the major ones being the Johns Hopkins, Bayview (formerly Baltimore City) and Howard County hospitals (see below), and Johns Hopkins Community Physicians (see below). The system also operates long-term and home care services, several outpatient facilities not on the East Baltimore campus, and separately incorporated entities providing administrative services to the medical center.

During its first years, the parts of the health system operated quite autonomously and there was little consolidation of hospital functions,[81] probably reflecting Heyssel's skepticism about the need for the health system. During the 1990s, however, several of the financial and administrative departments were combined. The health system now centrally administers general accounting, accounts payable, payroll, cash management, billing, budget, and business planning for the Johns Hopkins and Bayview hospitals, and, in some cases, for Howard County General Hospital.[81]

Robert M. Heyssel Building for Outpatients

Despite Hopkins's many virtues, care of outpatients was not one of them, and this applied to all, regardless of insurance status or personal wealth. Outpatient offices were scattered in seven buildings throughout the campus[64] and communication among the doctors and various clinics was, to be generous, unsatisfactory. Patients registered for care in twenty-eight different sites.[64] Billing and collecting for services given to outpatients were primitively administered. Edward Halle remembers that "some of the bills were in shoeboxes. I guess Bob assigned that job to me because I'd been a shoe manufacturer before coming to Hopkins."[11]

Heyssel's final gift to Hopkins was the construction of a $140 million outpatient building that stretches west across Broadway from the original hospital buildings and opened in the spring of 1992.[101] The Heyssel Building is con-

nected to a new garage on the west and to the hospital through an underground tunnel on the east. In addition to 191 examining rooms, the building also includes eight operating rooms, sixty-eight procedure rooms, twenty-eight radiology imaging rooms,[102] and the offices of several departments such as radiology and otolaryngology-head and neck surgery.[55] Heyssel's vision[11] was to build "a hospital without beds, not just an outpatient building."[55] With the collaboration of his staff, particularly Stephen Lipstein, then the executive director of the Outpatient Center,[103] and many members of the faculty in the medical school, especially Michael Johns,[104] then an associate dean in the medical school with particular responsibility for the full-time faculty's practice plan, Heyssel designed the building to overcome the problems previously associated with outpatient care at Hopkins. The employees staffing the building were trained to provide courteous, efficient service[55] and were garbed in gray and blue business suits.[101]

Securing the support and participation of the leaders in the medical school to build and maintain the outpatient building taxed Heyssel's renowned persuasive powers.[11] He persisted, however, believing that health care at Hopkins would increasingly be conducted outside the hospital. "Bob read the tea leaves early," remembers Edward Halle. "This produced a bit of hospital/school stress, but he was preparing us for the future."[11] And the faculty has gradually responded. "The Hopkins docs are more worldly now," says former hospital chief financial officer Irvin Kues. "They've taken to outpatient work more than they would have thought they would."[65]

The facility provides care for all patients who come to Hopkins for outpatient care, regardless of their financial status. Traditionally, in most teaching hospitals, private and ward patients came to different clinics, the private patients cared for directly by the faculty and the service patients primarily by the house staff and students. Many faculty members objected to their paying patients waiting to see their doctors in close proximity to poor patients seeking free care. In cities like Baltimore, the distinction between who could pay and who could not was often racial. It had been no more than thirty years since hospitals like Hopkins had desegregated their "white" and "colored" wards.

By the late 1980s, when the building was designed, all patients had become "private," in that a member of the faculty supervised or directly administered the care of every patient, whether directly referred to the faculty member or, unreferred from another doctor, had walked into one of the clinics or been brought to the emergency department by ambulance. Heyssel overrode the

traditional private versus ward separation and built one comprehensive facility where patients would be seen in units allocated by specialty and disease rather than by ability to pay.[55]

The hospital and medical school shared the cost of constructing the building, the hospital paying about two-thirds and the medical school one-third, with the hospital carrying the debt on its books.[64] Here lies one of the main complaints about Heyssel's pre-retirement present to the campus. As the clinical departments reluctantly pay their portions of the construction and operating costs of the facility, the directors and division chiefs complain about the size of their obligations.[53] "It's a great place to practice," says former cardiology chief Dr. Kenneth Baughman, "but it's too expensive."[105] Outpatient care does not pay well, and the operating costs of the luxurious Heyssel Building compare poorly with what it costs to run an efficient, economically equipped doctor's office.

The faculty object to having to contribute to the construction and maintenance of the handsome and impressive public areas. "Some are dazzled by the slick, contemporary look," says Judy Reitz, the hospital's chief operating officer. "Others find the airport, banklike look intimidating."[106] Furthermore, its arrangements are somewhat inefficient, not best designed for interdisciplinary or multipurpose use. Although the Heyssel Building could use some renovating, Hopkins would rather spend its funds constructing more off-campus sites for outpatients.[106]

Health Care Financing in Maryland: Health Services Cost Review Commission (HSCRC)

When James Block succeeded Heyssel in 1992 as president of the Johns Hopkins Hospital and Health System, he would be working in a state that would soon become the only one in which a governmental agency regulated the rates hospitals received.

In the late 1960s, the cost of hospital care in Maryland was rising so fast that in only three or four other states did being hospitalized cost more. To deal with this and other problems in the state's ability to deliver health care, the legislature created, in 1971, the HSCRC, which the state charged to reduce the rate at which the money paid to hospitals in Maryland was growing.[89,107,108] While containing costs, the commission was also charged to assure that all citizens

could obtain hospital care and ensure the solvency of what the legislation called "efficient and effective" hospitals.*

Several constituencies favored formation of the HSCRC. The leaders of the inner-city hospitals, and these included Johns Hopkins and Baltimore City as well as the University of Maryland, needed financial relief for delivering uncompensated care to patients without insurance or private means. Besides carrying a disproportionate share of uninsured or poorly insured patients, these institutions also conducted expensive teaching and research programs.[81] In addition, city leaders, state legislators, and the governor had become particularly concerned that some hospitals might close, thereby depriving residents of the medical care they needed. Employers complained of the rising costs of providing health insurance for their employees, and the administrators of Medicare, Medicaid, and private insurance companies wanted to contain the rapidly rising costs of care. Whereas in Philadelphia two insurers provided most of the private medical coverage, only one private insurer, Blue Cross, dominated this market in Maryland[107] which, with Medicare and Medicaid, provided insurance coverage for 80 percent of Maryland residents.

The commission would accomplish its missions by exercising its power to define the rates hospitals could charge for their services. In what came to be called an "all-payer system," the HSCRC's plan required that all insurers, including Medicare and Medicaid, pay the same rate, negotiated in advance, at each hospital. The amount varied as defined by a dialogue between the commission and each hospital.

Since Medicare and Medicaid were federal governmental programs, the commission had to obtain a waiver from these insurers allowing the commission to establish what they would pay for hospital care in Maryland. The waiver stipulated that increases in the hospital rates charged through the HSCRC must not exceed the average of such increments elsewhere in the country. With application of this formula, Maryland's rates gradually fell in comparison with those in other states. Whereas hospital costs in Maryland were 23 percent above the national average in 1974, by 2001, the average national rates exceeded Maryland's by 6 percent.[109] If the cost per admission in

* As the twenty-first century began, the Health Services Cost Review Commission regulated the rates that can be charged by each of the sixty-one hospitals in Maryland: fifty general hospitals, five that care for patients with chronic diseases and other specialties, and six for patients with psychiatric illnesses.[89]

Maryland since 1975 had risen at the national rate instead of the lower rates produced by the rate-setting system, the cost commission reports, expenditures on hospital services in 1995 alone would have been $1.4 billion more than they became.[109]

Before the HSCRC began operating, most hospitals, including those in Maryland, lived in the nirvana of "cost-plus" accounting, whereby hospitals charged what they determined their services cost plus enough to generate a surplus. Now, hospitals in Maryland would enter the world of prospective financial compensation since the commission would establish how much it could charge during the next year. The effect of the commission's actions meant that, as Harold Cohen, the first executive director of the HSCRC, said, "We were doing 'inflation plus one' while the other states were doing 'inflation plus 4.' "[89]

By keeping the rates within the bounds required by the Medicare waiver, the HSCRC reduced the rising cost of medical care in Maryland while bringing partial financial relief to those hospitals with many patients on Medicaid. When the inner-city hospitals complained that even this plan inadequately compensated them for this responsibility, the Maryland Hospital Association "brokered a deal that the commission accepted," described Cohen, "whereby every hospital paid into a pool" from which the hospitals with large numbers of patients without financial resources, like Hopkins, could draw. In Maryland, "it's important that we no longer have a charity hospital," said Harold Cohen. "It's better that all hospitals share the uncompensated care."[89] The HSCRC also provided other benefits. With the commission requiring hospitals to increase the amount of data they reported, the public as well as the HSCRC gained access to significant amounts of previously unreported financial and operational information.[107]

Maryland was one of the first states to regulate rates in this manner under the provisions of a "Medicare waiver," as the arrangement with the federal government is often called. It would also be the last. By 2002, only in Maryland would a state governmental agency regulate hospital rates.[107] Why is Maryland different? Cohen believes that the waiver is one reason. He adds that the citizenry, which has a liberal political bent in Maryland, a state of manageable size, seems comfortable with regulation.[89]

Few for-profit hospitals operate in Maryland, and the HSCRC is an important reason. "For-profits are about making money," says Robert Chrencik,

executive vice-president for finance and strategy at the University of Maryland Medical System. "They need market-level rates of return."[107] The commission rates, according to Chrencik, "allow hospitals to cover operating expenses and uncompensated care and obtain a modest amount of capital but no profit."[107] Furthermore, the commission forbids price-shifting, in which hospitals, particularly for-profit hospitals these days, force some insurers to pay premium fees to compensate for the lower fees collected from less generous sources. Accordingly, the surpluses that not-for-profit hospitals like Hopkins can earn in Maryland are relatively low, clearly less than the stockholders in for-profit hospitals and corporations expect from their executives. "Why fool around with Maryland when there's Florida and Texas?" Chrencik adds in describing the thinking of his counterparts who work at for-profit hospitals.[107]

Heyssel accepted the value of the Health Services Cost Review Commission. "Although not a fan of governmental regulation, I favor it, a net plus for academic medical centers."[55] Hopkins officials have joined other hospital executives in the state in helping to preserve this now unique agency. "We don't push to get rid of the HSCRC," says chief financial officer Richard Grossi,[110] "because we're better off with it. We try to fix it rather than walking away from it."[62]

Although generally approving the commission's purpose and work, financial officers like Grossi believe that the HSCRC "doesn't set proper rates for the academic medical centers," which means that the rates for the teaching hospitals, in his view, are still too low.[62] The $20 million margin the hospital earns on an $800 million expense budget is just enough to maintain the bond rating, limiting the opportunities for generating capital.[80] Without an adequate margin, hospitals cannot borrow money from the debt market for capital improvement.[81]

Philanthropy will support capital investment, and, in this sphere, Hopkins excels.[111] The State of Maryland provides a third source for capital. Even though Hopkins is a private institution, the state has contributed to the support of the hospital over the years, the most recent example being the Weinberg Building for patients with cancer.[80] Nevertheless, hospital officials continue to have difficulty developing financing for important major projects such as replacing and adding operating rooms, critical care units, and contemporary facilities for the children's service.[80] By the year 2000, hospital officials had determined that the debt of the health system could not be increased further.[111]

Although the HSCRC has helped Maryland hospitals weather the reductions in payment that managed care has forced on hospitals elsewhere, the commission has not affected the income of physicians, for which it does not regulate payments. Accordingly, when HMOs try to lower the rates they will pay for health care for their subscribers in Maryland, the reductions can only be assigned to the doctors' charges since the hospitals' rates are fixed by the commission.[112] Consequently, if the physicians object to what an insurer offers to pay, they may try to force the hospital not to accept that contract.[112] Such conflicts exacerbate the financial differences between the hospital and the school of medicine.

Despite complaining about what they see as inadequate payment for their services, the hospitals realize that as managed care and the federal cuts in Medicare pressured their budgets, the Health Services Cost Review Commission provided a cushion for Maryland hospitals, preventing efficiently run and useful hospitals from serious financial turmoil. Maryland hospitals, however, pay a price for their current stability. The HSCRC prevented them from producing large surpluses as the Hospital of the University of Pennsylvania was able to do earlier in the 1990s. "A savior but also a governor," Furlong Baldwin calls it.[42]

Michael Johns Appointed Dean

As the 1990s began, the senior leadership at Homewood and East Baltimore was changing. William Richardson succeeded Steven Muller as president, Michael Johns replaced Richard Ross as dean of the school of medicine, Hopkins chose Alfred Sommer as the new dean of the school of hygiene and public health, and, in 1992, James Block became president of the hospital and health system.[49] Each of these leaders, in varying degrees, would participate in the extraordinary events to follow.

When appointed dean of the Johns Hopkins University School of Medicine, Michael Johns was leading, at Hopkins, one of the most successful departments of otolaryngology and head and neck surgery in the country. Since 1986, he had concurrently run the CPA, thereby appealing to the clinical directors who saw him as a strong internal candidate to succeed Ross.[63,68]

Born in Detroit in 1942, Johns received his bachelor's degree at the local Wayne State University and his M.D. degree from the University of Michigan

in Ann Arbor in 1969. Johns trained in surgery and his subspecialty at Michigan and started his faculty career at the University of Virginia, where he became professor of otolaryngology and maxillofacial surgery in 1982. Two years later, Hopkins brought him to Baltimore as chairman of the department. Although at Hopkins for only six years when the job became available, Johns made it no secret that he wanted to be dean.[113*]

Influential directors, such as surgery chief John Cameron† who served on the search committee, felt it "our mission to get the job for Johns. He was a surgeon, would get things done, and was from our generation," a worthy successor to those who had led the school in the 1970s and 1980s,[68] like Ross and Victor McKusick, the geneticist and former director of the department of medicine. Ross, who had named Johns both to his chair and to the leadership of CPA, was pleased with his appointment and, although keeping neutral publicly, favored Johns to succeed him.[56]

Ellis Island accounts for the new dean of the Johns Hopkins University School of Medicine having the same last name as the institution he was to lead. When his family immigrated from Lebanon in the late nineteenth century, a clerk substituted Johns for the family's name of Marieb, presumably because Michael's father's first name was John. The original family name survived as one of Michael Johns's middle names. Johns studied for the priesthood but explains: "After four years, my interest in biology exceeded my interest in celibacy." He decided to become a doctor.[61]

Johns began his deanship leading a school with a significant annual deficit rather than with the surplus that his predecessor had hoped to present to him. The $20 million assessment from Homewood and the expenses associated with the construction, equipping, and financing of the new Ross research building helped to produce losses in operating budgets for the first four years of Johns's term.[61] The school of medicine required an internal loan of $30 million to pay its expenses during this period.[62]

* The time of Johns's appointment coincided with much uncertainty at the university. Steven Muller was leaving the presidency, and his successor, William Richardson, was just starting. The university asked Ross to continue as dean for another year while stability returned to the administration at Homewood. However, Ross had become severely, although temporarily, ill. "I just wanted out," he remembers.[56,57]

† When asked why he did not want the job himself, the William Stewart Halsted and Alfred Blalock Professor of Surgery replied, "I love being a surgeon. I would have thought being a dean a detour from one's field."[68] Fiercely loyal to Hopkins surgery, Cameron believed that there was no better job than his current one.[68]

Most saw their dean developing into a good manager and characterized him as a "likeable man,"[68] "trying to find common ground,"[41] with "a very academic mind-set"[114] and "good values,"[41] who "hired strong, definitive chairs."[115] He added women and minority faculty members, previously infrequently present in the dean's office, to full-time positions there,[61] devoted time and resources to improving relations with the community in East Baltimore,[104] and led a revision of the curriculum that the medical students received very well.[104] Johns also developed a technology transfer program and created an office of corporate liaison to promote research between faculties and companies.[116] During his term as dean, the school of medicine created twenty-six new endowed chairs and raised more than $253 million.[116] The White House invited Johns to lead a group of medical school deans to suggest revisions in the Clinton administration's health policy as it related to the financing and roles of medical schools.[116]

Whereas James Block spoke in generalities, Johns, the surgeon, was more specific. He avoided "boardroom mentality" and "never forgot about people."[60] Seen as easy to talk with, a good communicator without affectation, Johns, one director said, "didn't politic you; so we trusted him."[82] He was criticized, however, for having difficulty making decisions. According to Furlong Baldwin, admittedly a strong Block supporter, "Mike would say 'I hate controversy,' and would say 'yes' to quiet things. I suspect he didn't tell Richardson everything that was going on,"[42] a characterization of the dean not supported by some of his closest colleagues. Eugene Sunshine, then the university president's senior vice-president for administration, said, "Mike quickly analyzed the relevant considerations, asked knowledgeable others their opinions, and decided and acted. I am quite certain that he kept Bill Richardson and all others in university administration very well informed."[104]

As a faculty leader who both before and during his time in Baltimore had performed research as well as practiced his specialty, Johns supported science and recognized its importance to Hopkins.[82,115,117,118] William Agnew, whom Johns had recruited from Yale to direct the department of physiology—he started at Hopkins on July 1, 1992, the same day as Block—describes the dean as "very engaged. He helped me build the department and met every assistant professor I hired. If a faculty member gave a bad lecture, you heard from him about it."[115] Whenever an opening for a department director developed, Johns continued the Hopkins tradition of recruiting highly competent chiefs.[104]

James Block Becomes Hospital President

The man with whom Michael Johns and many of the leaders of the medical faculty would fight for control of the future of the Johns Hopkins Medical Institutions was born in Dayton, Ohio, and graduated from Haverford College in 1962 and New York University School of Medicine four years later. After serving in the office of the Surgeon General in the U.S. Public Health Service helping to develop health programs for community, migrant, and rural health centers, James Block then trained in pediatrics and ambulatory medicine at the Strong Memorial Hospital, the University of Rochester's principal teaching affiliate. After practicing pediatrics and administering primary care programs in Rochester for eight years, he became, in 1979, president of the nine-hospital Rochester Area Hospitals Corporation before moving to Cleveland in 1985 as president of the University Hospitals of Cleveland, the primary teaching hospital for the Case Western Reserve University School of Medicine.

In January 1992, the trustees of the boards of the Johns Hopkins Hospital and Health System unanimously elected Block president of the two corporations, to take effect when Robert Heyssel retired on July 1.[119,120] "Jim really impressed us with his knowledge where managed care was and would go," Baldwin, Block's strongest supporter, said. "I talked to people in Cleveland. They were all annoyed we were taking him. Jim was by far the best candidate we saw."[42] Baldwin, who saw the new president as a fine potential member of the club that constituted the hospital board, agreed with him in "not thinking too much of the medical school" and thought Block prepared, as was Baldwin, to favor the hospital over the school when necessary.[31]

"There's no question. Jim charmed us," said John Cameron, who with Dr. John Stobo, director of the department of medicine, represented the faculty on the hospital trustee search committee to find Heyssel's successor.[68] Others described him as "the most silver-tongued person I've ever met," "charming and could talk a good game about academics," "a bon vivant, friendly and circumspect."

Block brought a new approach to decision making to Hopkins. He made his plans and carried them out rapidly, not the standard operating procedure in universities where routine, time-consuming consultations with faculty leaders are expected. Baldwin explained the reason that Block operated the way he did. "Richardson, Morris [Offit, chairman of the university board], Block, Johns, and I would meet for dinner. Decisions would be made, but they would melt

away. When he couldn't get decisions from the school on issues that had a time pressure on them, he'd simply go ahead and do it."[42] Richardson counters that "Jim would simply proceed as he wished," regardless of what the group had decided.[44]

When Block started in 1992, he questioned the management of financial affairs at the hospital. "Business underpinnings were weak. The clinical effort, of course, was terrific."[121] Block concluded that to improve the appearances of the finances, the hospital at the time was moving money around. "That worried me. Had this happened in the past? Were the numbers I received OK?"[121] When Block asked outside accountants for advice, board members discouraged him from hiring new auditors. Block threatened to leave if they persisted. "I won. The new firm wrote the longest management letter in their history."[121] Within eighteen months, "we made the place more profitable than it had ever been."[122]

Many, even some of his severest critics, consider Block "brilliant," a highly competent medical entrepreneur, so successful that, as one senior clinician said, "the president of the hospital [no longer the dean] had become the dog, not the tail as before." "I think Jim was the architect for the whole system we see today," said hospital and university trustee Calman Zamoiski.[37]

"Jim had energy to burn, to experiment," observed Paul McHugh. "The world was changing, and everything was in play."[123] Describing Robert Heyssel as the "Jim Block of the 1980s," one administrator emphasized how much both of these leaders of the Johns Hopkins Hospital were ahead of their times.

"An impatient man," McHugh added, "the parliamentary approach was not for him."[123] Block saw part of his role at Hopkins to teach his new colleagues how to respond to managed care. Before Block, a longtime executive there observed, "Hopkins had no use for the HMOs. We wouldn't respond to their mail, answered their calls slowly, and said, 'We don't want you.' " Hopkins was not even meeting the deadlines the HMOs required.[35]

Throughout the controversy to come, Block enjoyed continuous, strong support from some of the most influential senior members of the Hopkins medical faculty, including, in addition to McHugh, the surgical chief John Cameron and Patrick Walsh, the director of urology. Block particularly pleased the surgeons by facilitating the construction of a new hospital building that included new operating rooms for which they had been pleading for years. The support went both ways since Cameron's and Walsh's departments contributed heavily to the hospital's income. Many patients, some with great

wealth, had come to Hopkins specifically for Cameron, Walsh, and their colleagues to operate on them. "Bob [Heyssel] believed these patients came primarily to the hospital, not to the doctors," Walsh says. "*You* build the ORs; *you* make the money from them," Heyssel had told Walsh, a doctor whom Baldwin calls "one of our profit centers."[42] Describing what he saw as a basic difference between the two men, Walsh said, "Block *listened* to you; Heyssel *told* you."[69] Walsh and others, not taken with the former hospital president, would call him "Bottom-Line Bob." "I was never a Heyssel fan," Walsh explains, "because whenever I called or wrote him a letter, Bob never responded nor gave any appreciation for everything that my department and I did for his hospital."[69*]

Although Block would only lead the Johns Hopkins Hospital and Health System for four years, he takes satisfaction in:[124,125]

- improving the finances of the health system.†
- building a new clinical center for patients with cancer with much needed operating rooms, a new emergency department, new facilities for the departments of ophthalmology and urology, and a VIP suite of luxurious patient rooms in the old Marburg Building.
- consolidating the widely scattered laboratories for the department of pathology.
- upgrading security on the East Baltimore campus.
- improving relationships with the HMOs and building a managed care office to service the contracts, which grew from three to thirty-five during his term.
- expanding the international program that attracted patients from overseas.‡
- facilitating relations with hospital personnel by holding monthly meetings with each of the three shifts that any employee could attend

* Patrick Walsh, appointed director of urology at Hopkins in 1974, not long after finishing his training, achieved widespread recognition for improving the operation for prostate cancer, thereby reducing the incidence of the previously all-too-common complications of postoperative bleeding, impotence, and incontinence. The success of the operation, often performed on men in the most productive phase of their lives, brought large endowments to his department and the hospital. Walsh and his colleagues annually perform about 1000 prostatectomies for cancer, the most frequently performed surgical operation at Hopkins.[69]

† The health system lost $4.1 million in the 1992 fiscal year (July 1, 1991, to June 30, 1992), the year before Block arrived, and produced a surplus of $16.6 million in fiscal 1997, Block's final year.[126]

‡ From between $4 and $5 million when he arrived to about $25 million when he left.[126]

and ask him questions. "We reduced the workforce without laying people off and developed the best relationships possible with the labor unions."[125]

— assembling a package that successfully dissuaded Paul McHugh, director of the department of psychiatry, from leaving Hopkins when offered a particularly attractive job elsewhere.

— developing a long-range master plan for building on the East Baltimore campus.[21,127*]

— creating Johns Hopkins at Green Spring Station.

Green Spring

Although the new outpatient building solved a long-standing problem on the East Baltimore campus, Block questioned the value of its construction, which had been a major effort in his predecessor Robert Heyssel's final years. Block thought it too grand and not the best investment for the purpose.[123] Unlike Heyssel, Block favored placing such facilities where the patients lived. "Bob didn't want to go outside East Baltimore," remembers Gil Wylie, one of his former administrators. "He wanted the docs there, admitting all their patients there,"[100] a point of view to which many full-time Hopkins doctors would subscribe.†

Block thought his hospital would not survive unless Hopkins related more successfully to community hospitals and physicians and the patients they served.[128] His initial solution was to build a large outpatient complex at Green Spring Station, eleven miles from the East Baltimore campus, just north of the beltway surrounding Baltimore. Following demographic considerations,[129] he selected a site convenient to patients and Hopkins doctors who lived in the nearby upscale suburbs. Prodded by Block, the Johns Hopkins Hospital and Health System, not the medical school, built Johns Hopkins at Green Spring Station over the objections of members of the senior faculty who could not envision that Hopkins doctors would want to work there.[128]

With the medical school objecting over costs and doctor participation,

* The plan, modified but retaining many of the features Block's plan had included[21] with a $1 billion budget, was announced in May 2002,[127] almost six years after Block had left Hopkins.

† One of the Hopkins's busiest community-based specialists says that many of the clinical leaders in East Baltimore always think in terms of "Broadway Central," referring to the major north-south avenue within the Hopkins medical campus.[128] Given the chance to practice in the suburbs, the practitioner says, a typical full-timer might respond, "We're Hopkins and don't have to do it."[128]

Block withheld describing, in advance, all his plans for the development of Green Spring. "I suspect if he was open," said one of the members of his staff, "it wouldn't have happened." Although Block denies hiding anything, he nevertheless acknowledges, "I know Mike felt I did."[122] This sequence increased the discomfort of the dean and many members of the faculty and contributed to the turmoil that followed.

By borrowing against its endowment, the health system financed the building and outfitting of a 75,000-square-foot structure, costing about $12 million—"minor money compared to what hospital buildings cost,"[131] according to Ron Peterson, the current health system CEO. The activity at Green Spring has increased visits at the outpatient building downtown by patients willing to come to East Baltimore for subspecialty consultations and procedures but preferring to see their Hopkins doctors at the suburban center for more routine care. The facility has also helped to secure and increase inpatient admissions to the Hopkins hospital, a fundamental reason for its construction, by patients who might otherwise use community hospitals even for more sophisticated operations and treatments.[131]

By 2002, all agreed that the venture has been a great success,[131,132] so much so that a second office building was recently acquired and is fully rented.[131,133] Surprisingly to many, Green Spring has been accepted as an extension of Hopkins. "It really feels like Hopkins," says Richard Grossi.[62] "It's Hopkins quality care without going into the city," adds Peterson.[131]

Most of the doctors who see patients at Green Spring are based there. Hopkins requires that Green Spring be their primary office, and each must qualify for an appointment to the Hopkins faculty.[100] Most are primary care physicians or nonsurgical specialists.[130] About seventy-five are self-employed, part-time members of the faculty.[131] They admit most of their patients to the Johns Hopkins Hospital, and can participate in the medical school's teaching programs. About 150 members of the full-time faculty also see patients at Green Spring on, what Gil Wylie, who developed the Green Spring project, calls a "per session basis."[100]

Green Spring "has paid off," according to Wylie, "by giving our private docs a supportive environment to keep sending their patients to Hopkins"[100] and thus bypass the suburban hospitals. Hopkins also believes that the presence of Green Spring has reduced the likelihood that other hospitals in the region will be able to recruit clinicians with large and valuable practices. Green Spring, according to Wylie, "is the largest single source of new patients to the Johns

Hopkins Hospital and school of medicine. The annual benefit to Hopkins approaches $100 million."[100]

Those critics who claim that the unit itself loses money are wrong, says Wylie. "We're breaking even. Our philosophy is not to make money on the project itself. None of the private practices have gone south."[100] Finally, by owning the property on which the Green Spring clinical buildings sit, the health system can prevent sequential selling by a developer that might change Hopkins's vision of the place. "So it's very helpful to be the landlord," says Wylie. "Ownership gives control."[100]*

The Green Spring success has led Hopkins to create another suburban clinic in a shopping center in White Marsh, northeast of Baltimore off Route 95, the highway to Philadelphia. The new offices are located fifteen miles from the main medical campus and seven miles from Bayview.[100] Most of the doctors are primary care physicians, some in private practice, some employed full-time as Johns Hopkins Community Physicians. The Wilmer Eye Institute, the renowned Hopkins eye service, operates an outpatient unit there.[131]

The success of these off-campus sites has helped to confirm the medical school's practice of running a clinical faculty of both full-time and privately practicing physicians, both with admitting privileges to the Johns Hopkins and Bayview hospitals. Hopkins leaders debated whether to "move more toward a solely full-time system or allow more volunteer doctors into the system in the 1980s," remembers Chip Moses. "The decision was to keep it as it was, part full-time, part volunteer. No services were entirely full-time, although some were more so, such as surgery."[66] "The vision that Block brought," says Wylie, "was breaking down the wall between the full-time and part-time Hopkins docs in the same structure. It opened people's minds so that you could be a Hopkins doc without being at Hopkins."[100]

Merging with Sinai and Other Hospitals

Despite widespread opposition when first proposed, the Green Spring strategy, even the most critical of Block's colleagues came to acknowledge, was an outstanding accomplishment of Block's presidency. Less successful, however, were his efforts to associate with, if not buy, community hospitals in prosperous communities, much as William Kelley had done at Penn. One of the

* Green Spring charges its physician-tenants $24 to $27 per square foot.[100]

hospitals that particularly attracted Block was Sinai Hospital of Baltimore. In the 1980s Heyssel had considered but decided against bringing Sinai into Hopkins. "Why take over their high debt and in a marginal location?" he reasoned. "Besides, we couldn't raise money like the Jewish community can."[55]

One of the oldest Jewish-sponsored hospitals in the country, Sinai, founded in 1866 (the year before Johns Hopkins established the university and hospital and decades before the Hopkins hospital opened), cherished its teaching and academic associations with the medical school.[134] Long located across East Monument Street from the Johns Hopkins Hospital and adjacent to the medical school, Sinai, in the 1950s, had built a new hospital in a suburb of Baltimore where many Jewish families were then living.

Unlike most community hospitals, Sinai had always maintained a strong academic component and employed a large, full-time staff of doctors.[134] Medical students and residents trained at Sinai, and those members of the staff who participated in teaching and supervising their work held appointments on the Hopkins faculty. Warren Green, the CEO of the entity that owns Sinai, describes the relationship between the two hospitals, however, as "love/hate. Hopkins loves the student experience here, which they rate high, but we compete intensely for patients, especially for tertiary [advanced specialty] care."[134]

Block had come to Hopkins in the midst of an era in which many leaders of large hospitals believed that they had to own feeder hospitals to increase their attractiveness to managed care. The doctors and staff at Sinai were uneasy about the prospect of becoming part of Hopkins. "They wanted to be closer to Hopkins, but not too close," Green says.[134]

After preliminary negotiations between Johns, Green, and Block, trustees and leading physicians of the two hospitals assembled for a joint meeting which revealed that their differences were irreconcilable. "The cultures were too different to allow any merger goals to be met," Green concluded.[134] At Sinai, many saw becoming part of Hopkins a betrayal of an important tradition. Their hospital would become a nonsectarian institution and no longer "the Jewish community's gift to the community," as Green describes an important part of the mission of his hospital, many of whose patients were no longer Jewish.[134]

That Hopkins would acquire managerial control over what was mostly a volunteer staff particularly alarmed many of the Sinai doctors—"the full-time power thing," as Green explains their anxiety.[134]* Executives and Sinai-oriented trustees feared that some would leave a Hopkins-run Sinai and admit

* In 2002, the Sinai staff consisted of about 1100 physicians, 150 of whom were full-time.[134]

to other community hospitals. "If we were in danger of failing financially," admits Green, "being run by Hopkins would not have been such a bad alternative, but we were not in financial danger, and, in fact, were thriving. So we can be best friends without being mates."[134]

Green, on behalf of Sinai, did look into participating in an association with several other community hospitals and Hopkins to negotiate more successfully with managed care, "the common challenge."[134] This arrangement, called the Atlantic Alliance, was a favorite of James Block, who described it as "an effort to build an integrated system including leading hospitals in every county surrounding Hopkins."[135] Within Hopkins, however, Block could not bring the medical school and university on board. The group fell apart as the threat of managed care diminished, and "besides," adds Green, "there was much mistrust of Hopkins." Green sees this effort as the "last hurrah for any major initiative with Hopkins."[134] In 1998, Sinai formed a corporation called LifeBridge, which included Sinai's hospital, rehabilitation, nursing home, and assisted living facilities with another community hospital. LifeBridge retained the names of the original organizations, including Sinai Hospital. As Green explains, "retail is individual, wholesale is LifeBridge."[134]

Wanting to build "the consolidated network we needed,"[135] Block considered developing a tighter relationship with Good Samaritan, a community hospital where the Hopkins orthopedics service was based. Block believed that Hopkins should try to prevent Helix, a local not-for-profit hospital corporation, from acquiring it even if this meant buying Good Samaritan for the Hopkins health system. Helix won this one because, in Block's opinion, Michael Johns "couldn't make this happen" at the medical school. "We needed a very strong front between the health system and the medical school to prevent Helix from getting it." Block believes the loss of "Good Sam" an important missed opportunity. "For Mike," he says, "this was just another skirmish."[135]

Despite the support of his chairman, Furlong Baldwin, for much of what Block wanted to do, his continuing efforts to develop a broader network for Hopkins met with opposition from some of the hospital trustees.[35,51] Eddie Dunn remembers how the health system trustees kept asking Block, "How will it work? How will you execute the plan?"[35] Block would present his ideas to the trustees as fully developed proposals requiring immediate decisions.[51] "A good example," thought hospital trustee George Bunting, of Block's "good instincts, [but] the way he did it was wrong."[51] Many of the trustees remembered the heartaches caused, in Heyssel's time, by the purchase of North Charles and Wyman Park hospitals and the attempt to integrate the doctors who had little

loyalty to Hopkins into the medical school's faculty. "These influenced us," said Dunn, "that dealing with groups of nonacademic doctors was violently different than with paid faculties. Bayview worked because the docs were academic and Ron Peterson and the faculty were ours already."[35] The boards favored using what capital there was or could be raised for construction and renovation of hospital buildings in East Baltimore.[35] At the medical school, faculty members would fault Block for trying to align the august Johns Hopkins with "hospitals of questionable merit."[53]

Johns Hopkins Health Plan

An enterprise that would bring James Block as much criticism as Green Spring Station had brought him praise began long before he arrived at Hopkins. In the late 1960s, a group of citizens in the depressed area surrounding Hopkins had formed the East Baltimore Medical Plan to provide care for local residents.[55,136-138] Always short of funds, the plan borrowed, rather than paid for, the medical services the Hopkins hospital gave to its members. As the debt grew to more than $4 million by 1983, Heyssel assigned Barbara Hill, one of his recently hired administrators, to sort out the problem.

"I found a mess," she remembers.[138] Hill wrote a new business plan for the prepaid group practice, and Heyssel assigned her as the director. "I set about economizing, and it became clear we could do it," she found.[138] In 1984, Hill and Heyssel, using the debt as leverage, convinced the local board to sell the plan to the Johns Hopkins Hospital, which changed its name to the Johns Hopkins Health Plan. In taking on the project, Heyssel was responding to criticism that the hospital should pay more attention to the health needs of the economically deprived local community. Some members of the faculty had criticized him, in the 1970s, for ignoring the residents of East Baltimore in favor of the more upscale citizens of Columbia, Maryland. "I wanted to do it because it was right," he explained, "not just to keep the liberals at bay."[55]

"We grew the baby," says Hill,[55] who offered her patients the advantages of private medical care in place of the discomforts and inconveniences of the clinic-type care that they were used to receiving at Hopkins. As the changes became known, the plan attracted most of the patients formerly attending the Hopkins primary care clinics who now could make specific appointments at the plan's offices and receive continuing care by trained primary care physicians.

Many of the patients whom Hill attracted into the plan had become accustomed to using the Hopkins emergency department for their care when the clinics were closed, despite having to wait hours before being seen. Hill arranged for nonemergency plan members to be shuttled by bus from the emergency department to one of her nearby clinic sites or to an urgent care center which the plan had opened and which operated until 10:00 P.M. By diverting patients not needing acute care from the emergency department, the plan allowed the staff in the hospital to concentrate on those more appropriately requiring care in such a setting.

Hill also insisted that, when her patients required operations, faculty surgeons and not surgical residents in training perform them. The director of the Hopkins department of surgery agreed to assign the care of these patients to younger members of his staff who often performed the preoperative evaluations in the plan's clinical offices and not at the Hopkins campus. The operations themselves were always conducted at the Johns Hopkins Hospital. With the plan providing increasingly efficient outpatient and inpatient care, Hill's charge became a profitable enterprise for Hopkins, not a money-losing source of patients for the hospital as it had been under the previous management.

Not pleased, however, by the success of Hill and Heyssel's health plan were faculty leaders at Hopkins responsible for providing training opportunities for students and residents. The plan was attracting patients who no longer came to the hospital clinics to be cared for by trainees. When admitted to the hospital, their care was supervised by the plan's full-time physicians, rather than by the house staff who no longer controlled their evaluation and treatment. Managing their care in this manner, of course, helped to explain how the plan could operate economically. Care by trainees is more expensive than care rendered by experienced doctors. Trainees take longer seeing their patients, order more tests, admit patients more frequently to the hospital—a particularly expensive way to render care—and keep the patients in the hospital longer. In addition, evaluation in an emergency department, where trainees may provide some of the care, for illnesses suitable for treatment in outpatient offices is expensive and inefficient.

As with some of the North Charles and Wyman Park doctors, Heyssel and Hill were employing physicians quite unlike the usual Hopkins doctors. Few had graduated from the school of medicine or trained in its departments and would, ordinarily, not be considered suitable for appointment to the staff or to faculty positions in the school of medicine. Under pressure from Heyssel, the

dean and the school agreed to give them junior faculty titles, which was necessary for them to receive admitting privileges to supervise the care of members of the plan in his hospital in the approved economical manner characteristic of HMOs. Heyssel remembers the issue of "who was qualified" as setting up "big arguments."[55] For this and other reasons, Hill was not a favorite at the school of medicine. "She never fit into the expectations of department directors," remembers psychiatry department director Paul McHugh, who faulted Heyssel for employing her. Not much appreciated by the Hopkins loyalists was her statement, "I'm here to bring the real-world market forces to these academic physicians."[138] Heyssel was trying to lead the Hopkins faculty in unfamiliar directions.[48]

Despite such problems, familiar to leaders in clinical departments in all medical schools, Hill and Heyssel were certain that they were delivering significantly better care to their patients than they had received at the Johns Hopkins Hospital clinics and emergency department previously. "We felt like rebels with a cause," Hill remembers.[138] The department of medicine responded to the falling census in their clinics by assigning house officers to offices of the plan close to the Hopkins campus. Hill welcomed them even though their presence made operations somewhat less efficient.[138]

Before many other leaders of similar hospitals, Heyssel had become convinced that the Hopkins hospital had to adjust to the coming of managed care. He feared that, unless his hospital took a leading role, its census would fall as HMOs directed their patients to other, less expensive institutions. Accordingly, Heyssel convinced his board that the Johns Hopkins Hospital should extend its HMO, which until then only served the East Baltimore patients. He envisioned a commercially viable HMO with the goal of insuring more than 100,000 clients. He called on Barbara Hill again, and, using the HMO license Hopkins had inherited from the East Baltimore Health Plan, hired a sales force and attracted customers in Maryland, southern Pennsylvania, Washington, and northern Virginia. While Hopkins operated it, the number of members doubled each year, reaching a total of more than 110,000 by 1991, and the plan became profitable, earning a surplus of $2.48 million during the fiscal year ending June 30, 1990.[139] About half of the members were on Medicaid. "We made our money on the Medicaid patients," Heyssel said.[55] Whereas elsewhere the state and federal governments paid hospitals poorly for their care, in Maryland the Health Services Cost Review Commission directed that Medicaid pay the same rates as other carriers.

Despite these accomplishments, however, the hospital sold the health plan seven years after buying it. Continuing success, Heyssel became convinced, would require further expansion and increasing financial risk to the health system. "We discovered a fact of life," Heyssel said. "We couldn't build an HMO that was really large enough to be fully successful."[55] Competition for members among the traditional health insurers was growing, and Hopkins failed to convince the larger companies in the region to choose the Hopkins plan for their employees. Several of the hospital trustees with insurance backgrounds warned, as Barbara Hill remembers the discussions, "if the underwriting cycle went bad, large losses could develop and endanger the endowment."[138] Furthermore, the HMO continued to be a source of friction between the hospital and the medical school faculty who opposed the Hopkins name being used by physicians whom they saw as non-Hopkins-type doctors who staffed the clinics.[140] Convinced that continuing to operate an insurance company was becoming "a distraction from our core business,"[141] Heyssel decided to sell the HMO. "God created hospitals and insurance companies," he told Nelson Sabatini, the State of Maryland's secretary of health and mental hygiene.[141] "Docs shouldn't run HMOs, and insurance executives shouldn't run hospitals."[141]

Although Hill opposed selling the plan,[138] she followed Heyssel's and the board's instructions and solicited proposals from several potential buyers. The board of the health system concluded that the Prudential Health Care Plan, Inc. offer was the best.[142] Accordingly, in May 1991, Hopkins sold the insurance part of the Johns Hopkins Health Plan to the Prudential Insurance Company of America for $18 million while retaining the group practice, into which the Wyman Park group was integrated, and some of the nearby offices as community clinics.[139] As Heyssel summarized what happened, "We got out of the insurance business and retained the provider side."[55] The insurance company hoped to make managed care for Medicaid patients a profitable activity since, as Sabatini said, "that is where the states were going."[141]

According to the terms of the sale, Prudential would direct some of its patients to the eighteen medical clinics Hopkins would continue to operate throughout the state, four of which were in East Baltimore.[143] The hospital agreed not to start its own HMO for ten years, a provision that would soon haunt Hopkins. The contract also prohibited the Hopkins doctors working in what had been the Johns Hopkins Health Plan from seeing patients under contract to HMOs other than Prudential's. As is characteristic of such arrange-

ments, the insurer collected the fees from the state, deducted its administrative costs and profit, and returned the residue to Hopkins to care for the patients. Hopkins, meanwhile, assumed the financial risk should the cost of caring for the Prudential patients exceed what the insurer agreed to pay.

The Suit

Jim Block thought differently about the ultimate value of an HMO to Hopkins than did Heyssel and many of the trustees. He favored the health system's developing an HMO again but, more important, he wanted to staunch the losses the Prudential arrangement was forcing on Hopkins. The hospital was losing money on the deal as the insurer, in Block's words, "ratcheted down the payments and gave their clients new benefits without paying us for them."[122] Furthermore, more and more of the patients Prudential sent to Hopkins required expensive treatments that the fees in the contract did not completely cover.[141] The contract "terribly constrained us," explains Block. "We couldn't even do Medicaid contracting [which the state was about to require] or any other type of prepaid contractual care."[36,122]

In the Prudential offices in Newark, Block and Baldwin tried to convince the company's CEO to revise the contract. "Prudential had to realize our plight," Block says. "I faced having to cut support to the departments unless we could reduce the losses."[122] When the insurance company refused to adjust the terms,[36] Block asked Sabatini and Maryland governor William Donald Schaefer to help, but Sabatini knew that "the state could not undo a business deal."[141]

Block then "looked for some way to pierce the deal by finding something wrong with the contract," as Barbara Hill described what followed.[138] Believing that he had a good case,[122] Block, strongly supported by Baldwin,[36] arranged that the health system sue Prudential. The suit charged that the contract was flawed because, among other reasons, Hill had breached her fiduciary duties during the sale.[140] When Hopkins sold the HMO portion of the health plan, Hill left to become president of the Prudential Health Care Plan in the mid-Atlantic region, which had absorbed the former Hopkins plan.[144]

In February 1995, after months of well-publicized[140,143] litigation, the health system dropped the suit. Hopkins issued a public apology to Hill and ceased its

efforts to nullify the sale of the HMO.[145]* André Brewster summarized the result by saying, "The facts that could be proven simply did not establish the invalidity of the onerous contract."[36] On behalf of the university, Richardson had strongly advised Baldwin and Block against entering the suit, "because of the reputational risk involved."[44]

Sabatini saw the episode as a conflict between Hopkins, preeminent in the city, versus a very large, national company. "Unlike their accustomed dominance in Baltimore, they couldn't order around a Fortune 500 company," thought Sabatini, referring to Block and Baldwin.[141]† Prudential fought the suit because, in Hill's opinion, "It was worth it for them to fight in order not to admit they had done something wrong when they hadn't. Besides, what are big legal fees to Hopkins is a small investment for Prudential."[138]

The immediate effects were not pleasant for Hopkins. The *Sun,* which described the settlement as "a near total capitulation by the Hopkins Health System," quoted the now vindicated Hill as saying, "My parents taught me that when the schoolyard bully picks on you, you stand up to him. That's what I did, and now they've had to back down and apologize."[145] The episode meant that the costly contract would continue to drain the hospital's resources, even threatening its bond rating.[122] "It took us four years to reduce the losses to $1 million per year," explains Block. "We spent hours with Barbara in endless negotiations."[122] The resolution of the suit finished Hopkins's efforts to reenter the medical insurance business, aggravated the hospital's relations with Prudential, which insured many of its patients,[146] and exacerbated conflicts that were developing between Block and his colleagues at the medical school.

Johns Hopkins HealthCare, LLC

As Block was trying to break the Prudential contract,[140] the hospital and medical school decided to create an organization to better coordinate their approach to the insurers offering managed care contracts.[61,147]

The new corporation, named Johns Hopkins HealthCare, LLC (Health-

* Attorney André Brewster, a former hospital board chairman, led the effort to produce a settlement that included writing a letter of apology to Hill. "I told her we screwed up," he remembers. "Baldy nearly choked when he had to sign it."[36]

† Sabatini joined the University of Maryland Medical System, the other academic medical center in town, as executive vice-president for integrated delivery system development when his job in the state capital concluded with the end of Schaefer's governorship in 1995.

Care), and inaugurated in July 1994, would be "instrumental in showing the ability of Hopkins to talk with one voice" according to Dr. Edward Miller, director of the department of anesthesiology at the time.[148] Prior to the creation of Johns Hopkins HealthCare, HMO officers would first talk with hospital executives to establish the hospital's degree of interest, albeit at HCSRC-approved rates, and then would have to meet with the relevant department directors to work out what they would pay for the doctors' services.[97] The whole process was complicated by the fact that neither the hospital nor the school of medicine was "willing to concede total control to the other," according to HealthCare's first chairman and CEO, Dr. John Stobo.[148]

Many wondered why Stobo, director of the department of medicine, would want such a job that would require interrupting a distinguished academic career for an administrative post with an unknown future, potential instability, and the responsibility for managed care contracts, about which he, as well as most members of the faculty, had had little practical experience.[2,42,66,68,73,78,94,97,105,149] There were reasons, however. "Jack had been chair for ten years," his successor in the medicine directorship, Dr. Edward Benz, observed. "His [recruitment] package was gone, and he was frustrated" by the unavailability of new funds and space to further develop his department.[150] Furthermore, Stobo was being recruited to become dean of another leading medical school, a predictable event in the career of successful senior Hopkins physicians and investigators. Despite being told, "You don't leave the Osler chair," Stobo wanted a different job and, to keep him at Hopkins, the dean and hospital president offered what seemed to him a challenging opportunity dealing with contemporary issues. Saying, "Hopkins has to wake up," Stobo agreed to take the job.

There was more to the job than just managed care. Stobo, described as someone who takes on jobs with great enthusiasm, would also supervise the employees' health plan and Hopkins's participation in the Prudential HMO. HealthCare would develop networks of physicians to increase Hopkins's appeal to insurers offering managed care contracts. With Block and Johns contesting for leadership on the campus, Stobo saw the HealthCare CEO forming a bridge between the school, the hospital, and the community physicians, and exercising significant executive authority over the hospital and school. This, however, is not what happened.

Stobo's position, as it developed, had little power. "It was a no-win job, high on drudgery, low on glory," thought John Cameron, the head of surgery.[68]

Since neither the dean of the school of medicine nor the president of the hospital reported to Stobo, he could exercise little influence over them. Thus, Stobo had the least power of the three, and, to compound the problem, Johns Hopkins HealthCare, LLC, was the one of the three organizations that was losing money.

Many directors of the clinical departments, of which he had only recently been one, preferred dealing with the large insurers on their own.[2] "The problem was not so much that the departments contracted directly and independently with the payers but that our mechanisms of governance prevented aligning control, risk, and rewards," said Dr. Elias Zerhouni, director of the department of radiology.* "Departments had great trouble delegating management decisions and were able to veto each and every move of the institution, leading to loss of unity in action."[2] Finally, several directors complained that reporting to three executives—Block, Johns, and now Stobo—only complicated their jobs.[149]

When he took the job, Stobo believed that HealthCare "made sense as an organization." He soon discovered, however, that "no one really wanted it. Finance saw it taking money. The faculty saw it making deals not advantageous to them. The health system and the medical school never fully accepted it."[67]

In 1995, Johns assigned to HealthCare the job of consolidating the billing process for the fees generated by the full-time faculty with the aim of improving collections and saving money. If this could be accomplished, Hopkins would be able to generate a single bill for all professional services, a significant convenience for patients. Historically, billing and collecting for the doctors had been a decentralized process, with each department and several of the divisions sending out their own bills. Fundamentally unenthusiastic about the project, many of the directors objected to capitalizing the new venture. Nevertheless, Johns and Stobo went ahead, created a centralized billing operation in the suburb of White Marsh, disbanded the department-based billing operations, and reduced the size of the departmental staffs.

Rather than increasing collections, the new arrangement produced less income. Rising hospital admissions and outpatient visits added to the complexity of establishing the new system, as the central office workers, some inexperienced and their number deliberately kept low to save money, strained to keep up with the work. With the departments' revenue falling, "it wasn't

* In 2002, Zerhouni became director of the National Institutes of Health.

long before the inevitable happened," as one observer commented. "Grenades were lobbed, fingers pointed," as the frustration of the department and divisional directors and faculty mounted. Edward Miller expressed many of his colleagues' concerns about Stobo's organization. "Besides losing money, HealthCare had evolved into a life of its own, bigger than anything else and not accountable."[132]

Although HealthCare and its chief were lauded for "providing very important services at the time" and "doing a good job in a very difficult situation,"[131] Stobo's star was falling, and he was becoming frustrated with the job. In his words, "It was a very frenetic time. At the end of the day, one was out of breath. Some of the work didn't get us anywhere. We spent so much time walking the thin line."[67] Risk contracting for Medicare, dealing with which was one of Stobo's major responsibilities, had not grown as fast as Hopkins executives expected, and the billing fiasco had injured his reputation at Hopkins. Unlikely to advance to a more senior position there,[105] Stobo accepted the presidency of the University of Texas Medical Branch at Galveston in September 1997. There, as the *Baltimore Sun* explained, "he will get a new set of problems to solve as he oversees four schools, two institutes and seven hospitals."[148]

CHAPTER SEVEN

Unified Governance

For a century, the Johns Hopkins University School of Medicine and the Johns Hopkins Hospital, despite being governed separately, had coexisted and flourished, with faculty and staff dedicated to the same missions. Now, however, the conflict between the leaders of the two entities grew so intense that the boards of trustees had to enter the fray and, in the process develop what, for Hopkins, was a revolutionary solution.

Block versus Johns

Whereas former hospital president Robert Heyssel and medical school dean Richard Ross had maintained a controlled tension between them that worked for the benefit of the Hopkins medical enterprise, their successors could not do this. "Two alpha dogs in a kennel that's too small"[1] and "charismatic Jim versus scrappy Mike"[2] were the pictures two senior faculty members drew of the conflict. Mark Rogers saw the quarrel in historical terms. "It was Henry VIII versus the Pope. The dean was the Pope, the keeper of the flame and the reliquary, but the hospital director had the money, and the dean needed the

money. Jim, like the king, could make pragmatic decisions, whereas the dean had to bring the faculty along."[3]

The conflict did not seem preordained. Michael Johns had helped Block gain the Hopkins job.[4] In 1991, the two met at a retreat in New York at which Block was speaking. Impressed by Block's presentation,[5] Johns asked if he could nominate him to succeed Heyssel.[4] On returning to Baltimore, Johns described Block favorably to Heyssel and said that he supported Block's being interviewed for the hospital presidency.[5] At the time, Block was being recruited to lead another leading teaching hospital, but when University Hospitals of Cleveland, where he was then the CEO, offered him a new, generous contract, he rejected the offer.[4] Until Hopkins came calling, he had planned to remain in Cleveland.[4]

After Block arrived, he and Johns shared a strong friendship—for a while.[6] "They were thicker than thieves," remembers Colene Daniel, one of the hospital vice-presidents.[6] In time, however, the differences between their concepts and their characters separated them. The story went around that Johns had said when he became dean, "I could hardly wait till Heyssel left," but later, "when I got to know Block, I wanted Heyssel back!"

Some have suggested that one of the reasons Block and Johns were destined to fight is that each saw himself an expert in managed care and governmental organization. Accordingly, Block interprets the conflict with Johns as "driven more by policy differences than personality."[4] Both understood how managed care was disrupting all that was familiar to the faculty about the financing and delivery of health care. "Since their interests had more similarities than those of Heyssel and Ross, they clashed," said an observer of both regimes. "If a basic science person had been the dean, the trouble might not have happened."[7] Furthermore, Heyssel and particularly Ross had, in Steve Muller, the university president during their terms as hospital president and dean of the medical school, "a common adversary to concentrate on," a luxury not available to Johns and Block who, instead, fought with each other.[7]

Projects that Block wanted to emphasize but about which he could not bring the school and university to collaborate included:[8,9]

- Building "a common vision" on how to improve the conditions of the neighborhood surrounding Hopkins.
- Developing a children's hospital and educational center in the Inner Harbor in collaboration with the University of Maryland's department of pediatrics.

- Maintaining a coherent architectural vision for the hospital and the East Baltimore campus. In conflict with the more modernist aims of the donor and the university, Block wanted the exterior of the new nursing school, being built on hospital property, to harmonize with the brick veneer of the original hospital buildings. They compromised on this one.
- Developing what Block calls "a broader alliance of hospitals," in which community hospitals would be brought into union, in some manner, with the health system.
- Building an outpatient clinical center in a Washington suburb, as he had done to much eventual acclaim at Green Spring.
- Coordinating within the health system rather than the medical school the work of the physicians at Bayview and those who cared for the patients in the Prudential contract.

Under what Block calls "the double standard," the hospital president was expected to "run a good, profitable hospital, understand the academic culture, but keep his hands off the medical school while supporting it financially." The dean and university president, however, could interfere with hospital and health system affairs at any time, as he saw it. This produced "enormous tension between Johns, Richardson, and me. I seemed to be burning bridges every time there was a decision to be made."[4]

Block worried about the ability of the health system to prosper unless it took the steps he advised and which he saw the school and university opposing. "Hopkins had not done what it needs to protect itself," Block continues to believe. If the HSCRC and the Medicare waiver should disappear, "the for-profits would come in, and Hopkins would find its market position very vulnerable."[4] In Cleveland, Block's university hospital faced the continuing efforts of the highly successful Cleveland Clinic to attract and keep patients. This competition forced his colleagues at the hospital and on the faculty to do what was necessary to survive. "Every university hospital needs a Cleveland Clinic down the street," he came to believe.[4]

Gradually, the membership and attitudes of the opposing teams congealed—the dean and many of the faculty leaders on one side, Block, his staff, and supporters among the faculty and on the hospital board of trustees on the other. The conflict between Block and Johns became so intense that the observer has difficulty separating fact from opinion, so strongly do supporters of one criticize the other.[2,10-19]

"It seemed that every couple of months, there'd be a battle between them over rights," Paul McHugh remembers. "They kept the pot boiling. We spent most of our time wondering where justice lay. I hated that period when my loyalties were torn."[20] Members of the faculty described the atmosphere with such phrases as:

— "Johns versus Block, always pulling in opposite directions."
— "They were constantly fighting and not talking to each other."
— "The staffs were slandering each other."
— "The smoke between them became a raging fire."

One of the senior health system administrators remembers a retreat that Johns, Block, and their staffs held at a resort on the eastern shore of Chesapeake Bay, a favorite location for such occasions, away from the day-to-day activities in East Baltimore. "It was supposed to be collaborative, but the two teams just spent their time sparring with each other." Palpable discomfort accompanied most meetings that both Block and Johns attended.

Each criticized the other. Block found Johns's managerial skills wanting at times.[21] Johns, whose strategy compared with Block's was seen as more conservative[22]—Johns prefers the word *consistent*[23]—had particular difficulty dealing with what he called Block's tendency to propose "the deal of the day" and "the idea of the day."[24] Faculty members,[11] even those who most severely criticized him, agreed that Block was the better public speaker.

Beginning in June 1994, university president William Richardson began meeting weekly with Block, Johns, and some senior members of the staff in sessions that came to be called "the parlor group" because they met in the Baldwin Parlor in the Billings (Administration) Building, a room that included a portrait of the chairman of the hospital trustees.[25] Block was "smooth as silk but drove people crazy because he proceeded with what he wanted to do without telling us what he wanted to do."* According to several colleagues, when feeling he had been crossed by Block, Johns would become defensive. He seemed to interpret most of Block's actions as negatively affecting the medical

* Block strongly objects to the flavor of this and other comments suggesting he was "a used-car salesman," a characterization that he firmly believes is inaccurate.[26] He also denies doing things "behind Mike's back. He wasn't here enough, always attending meetings and conferences away from the campus. Things were moving so fast requiring a level of attention that made it very difficult to keep up to date unless you were here most of the time."[26]

school. "It was inevitable it wasn't going to work," explains an executive who attended most of the sessions.

Alfred Sommer, dean of the Bloomberg School of Public Health,* remembers how Block withheld his plans from his colleagues. At one of the regular meetings Richardson had arranged with Johns, Block, Sommer, and others to discuss health policy matters, someone asked Block what he suggested should be done about health care in Maryland. "He told us very little, as if he hadn't worked it out," remembered Sommer. "Then, a few days later, he laid out a whole program to the legislature. None of us, including Richardson, whose profession is health care economy, knew anything about what he was going to say."[17]

Block's frequent appearances before legislature committees angered Richardson. Block explains that, at the request of the speaker of the House of Delegates, he was advising a legislative committee about health insurance for small businesses, a subject with which he had significant experience.[26] "After eight or nine months, Richardson called my board chairman [Furlong Baldwin] and told him, 'Pull Block out of Annapolis'."[21] Baldwin confirms the story. "The chairman of a leading committee of the legislature had adopted Block as his consultant on health issues and managed care because of Jim's experiences in Rochester. When Richardson called me, I knew we had trouble."[27] Block was already well aware of this. Richardson had told him, "There's only room for one Hopkins president."[4]

"Baldwin was, like Block, a swashbuckler," says Richardson. "The difference was that Baldy had superb business sense."[28] Michael Bloomberg, who should know, agrees. "Business guys, like Baldy, tend to resolve ambiguities. He's an old-line, patrician business guy who knows how to make decisions."[29] As for Block, even Baldwin acknowledges, "Jim could be quite confrontational."[27]

Sommer saw what followed as "out and out warfare that percolated up to the trustees, who saw it more as Richardson versus Block than Johns versus Block"[17]—a perception confirmed by university board chairman Morris Offit.[30] The consensus developed that Richardson no longer trusted Block and had begun to favor merging the hospital and the university. He appeared irritated with the behavior of both of them and in meetings with Johns and Block seemed cool and distant. As for Johns, however, Richardson saw the dean as

* The School of Public Health is named for Michael Bloomberg, the founder of the highly successful financial information service and, since 2002, mayor of New York City. Bloomberg, who received his undergraduate degree from Hopkins in 1964, is Hopkins's most generous alumnus.

"a totally different personality from Block. He just wanted to make things work."[28] Johns understood better than Block how to gain the faculty's support.[31] Although more emotional and quick-to-judge than Ross and brash at times, Johns was, according to McHugh, "more legislative, more collegial. Mike lived within the faculty, balanced opinions, quietly winning people around."[20]

Richardson would serve as Hopkins president from 1990 to 1995, when he would leave to direct the W. K. Kellogg Foundation.[32*] His departure after only five years as Hopkins president, however, made some wonder how much the turmoil at the medical center might have influenced his decision. As one of the basic scientists said, "There's not a lot of glory getting involved in an all-out war. There would be no winners if all stayed to fight it."[34] Richardson clearly "wasn't willing," another observer close to the conflict suggested, "to spend his working capital trying to settle the dispute." Richardson "did all he could to make it work," says Eugene Sunshine, Richardson's senior vice-president for administration. "One of his greatest talents was getting people to work together. Even he was not fully successful."[35] Richardson acknowledges that "the fight didn't drive me away, but it was an irritant."[33]

The conflict was injuring Hopkins. "East Baltimore, at the time, was a nonfunctioning medical center," thought Sommer.[17] Many days, it seemed, brought another article in the *Baltimore Sun,* revealing the angst then growing on the campus.[36] After describing Block as having "a patrician manner," a writer in the *Sun* quoted some on the campus calling him as "a personable visionary" while others thought him "arrogant and stand-offish."[37,38] "Fighting the battle publicly was a bad idea," says communications and public affairs director Elaine Freeman, "but Block and Johns did it, and both lost from it. As you can imagine, this was a very difficult time for my office."[19] One board member suspected that faculty in the medical school were feeding gossip to the reporters.[27]

Eventually, the relationship between Block and Johns "deteriorated into a dogfight," remembers John Cameron, who had favored Johns becoming dean in 1990 and continued to support many of Block's initiatives. "Mike couldn't stop badmouthing Jim. We told him to stop."[39] As the battle between them

* "I couldn't turn down (or resist) an offer that so captured my history and my interests," explains Richardson, who had previously been a Kellogg fellow.[33]

grew in intensity, Johns, as well as Block, seemed vengeful and vindictive. Each thought the other a liar.*

Despite the conflict, however, "it was business as usual here," remembers Cameron. "The place went on automatic pilot. The governance battles did not upset the daily routine."[39] Cameron, a Hopkins veteran for more than forty years since he entered as a medical student from Harvard College in 1958, said, "My job and love is here in the department of surgery, not in medical school politics. I kept my head down to avoid the cross fire."[39] He believes that most of the directors and chiefs preferred to do what they were hired to do, running their units rather than becoming involved in the controversies. "None of us played major roles in how it turned out," he says, and when the governmental change occurred and a new leader was appointed, "it wasn't as if lightning had struck."[39]†

Guy McKhann, the neuroscientist and former director of the department of neurology who now works on the Homewood campus, adds, "the leadership issues, which were driving us nuts, didn't filter down."[40] McKhann is not alone in declaring that Hopkins continues to be a very successful institution despite its leaders, that it may be less leader-dependent than many other academic medical centers,[40,41] because as Jack Stobo observes, "the momentum, the trajectory are so strong."[41]

Block's Problems

Block had one deficiency that many thought accounted for many of his problems. James Block was not "old Hopkins." Before coming in at the top as the president of the hospital and the health system, Block had not been educated, trained, or employed at Hopkins. He was seen as insensitive to the institutional ethos of the faculty, most of whom were steeped in the Hopkins culture, described by one senior faculty member as "a common set of values

* When interviewed in Atlanta, Johns avoided criticizing Block and preferred to dwell on his other experiences there. "It brought back many memories of a great and challenging time at Hopkins. It is a place very dear and special to me, and I was glad to be able to make a small contribution to the institution. I always felt a responsibility to carry the torch for the entire academic enterprise, including our service mission and the integrity of what that stands for."[24]

† In addition to running his department, Cameron, an internationally respected authority on pancreatic surgery, operates four days per week and intends to continue doing so after his retirement in 2002 from the surgery directorship he has held for eighteen years.

of excellence and innovation." One of the department directors said, "We brought in Block, an incredibly creative person who understood the business of medicine. What he didn't understand was the culture of a research-intensive place like Hopkins." As one senior administrator said, "He believed himself above the law of the culture."

Although he cannot refute his lack of connection with Hopkins before becoming president, Block insists that he recognized the value of, and responded quickly to, the Hopkins culture.[21] Of the places he had worked, only at Haverford College, where he obtained his undergraduate degree, and at Hopkins could you "touch the culture. Those who don't reflect the culture stick out like a sore thumb. There's a kind of civility and cultural pressure that controls behavior."[21] At his first meeting with the medical staff, "I was introduced as 'President Block,' and everybody stood—such respect."[21] Block recalls the rituals surrounding the unveiling of portraits of senior faculty members. "Presenting the oil painting is almost a religious ceremony. There's great respect for former chairmen."[21]

Although few at Hopkins could describe the culture with greater skill than Block, most of the faculty believed that "he just didn't get it," as former university president William Richardson said.[28] Soon after Block arrived, Dr. Martin Abeloff, director of the department of oncology, invited him to discuss his plans with the senior members of his faculty. Block advised several times that they should strive to be more like large, free-standing cancer centers. "The wrong message to send to our faculty," Abeloff realized.[15] The Hopkins program, developing as part of a medical school, had been built on a unique research and teaching base. The faculty was proud of the traditions and accomplishments of the Hopkins program. "Image and increasing patient volumes," Abeloff thought, were paramount in Block's mind.[15]

Block's critics point to several of his plans that indicated his failure to appreciate the culture of the institution. Wanting to retain a surgeon with a busy practice, Block was prepared for the hospital rather than the school of medicine to pay him when Johns balked at giving the surgeon the arrangement he wanted.[27] Traditionally at Hopkins and at most other teaching hospitals, the school, not the hospital, employs the doctors who practice there. "Jim couldn't see that hiring the surgeon outside the medical school was out of the culture," said one of the basic science directors. "Mike was beside himself on this issue."[42] The surgeon left, but not before providing further evidence to Block's opponents of his lack of appreciation of the local culture.

Somewhat similarly, Block wanted to allow a particular group of former full-time cardiologists who had gone into private practice in the Baltimore suburbs to perform their cardiac catheterization procedures at the Hopkins laboratories, which had previously been closed to all but full-time cardiologists. The Hopkins doctors saw the members of this group as particularly hostile, "out to have our hides," as Dr. Stephen Achuff, a leading Hopkins full-time clinical cardiologist, describes the threat. "Ken [Dr. Kenneth Baughman, the cardiology chief at the time] and I told him not to do it, to show loyalty to the faculty. Jim couldn't care less, had no sense about Hopkins and the full-time faculty." Achuff remembers the episode as "a very distasteful experience."[43]

As clinicians were objecting to where they saw Block taking the hospital, the basic scientists feared that Block's efforts would affect research, that hospital resources would be diverted from academics into buying practices and hospitals.[14] Then, there were Block's plans for the Phipps Building. Hopkins loyalists censured him for wanting to replace this historic and handsome building, formerly the psychiatric clinic, with new construction.[44] Block explains that he had to find, very quickly after becoming president, space for a new cancer center building to preserve $30 million that the state had appropriated for this purpose. "Where we eventually put the building," Block explains, "many of the doctors thought, was too far away." So he selected nearby space, which included the Phipps Building. Eventually, the cancer center was built on the southern edge of the campus, where Block wanted to place it initially.[26] Phipps survived and now contains the offices of the hospital president and other executives.

"It's very tough to be the outside person with our ideas," observed Levi Watkins, one of Block's friends, advisers, and supporters from the medical school. "Jim didn't use the depth and breadth of the people from Hopkins around him. He decided matters without making his circle wide enough, particularly as the hospital's relationships became more complicated."[45]

And Block had problems other than the culture wars. One was tardiness. Block was chronically late for meetings and appointments and, sometimes, did not even appear at previously arranged engagements. "He paid no attention to the clock. That's just the way he behaved," explained one of the department directors. Baldwin, who had chosen him as health system president and remained his supporter throughout the difficult times, tolerated Block's idiosyncrasies. However, when he was late meeting with the more reserved George Bunting, who had succeeded Baldwin as chairman of the health system board,[46] Block received a dressing down: "You'll never be late again."

Block's Chief Operating Officer

Although some criticized Robert Heyssel for never appointing a chief operating officer (COO) while he was the hospital president, the same could not be said for James Block. The choice he made, however, caused him further grief.

Part of the chief operating officer's job at Hopkins was to say "no," something Block always found difficulty doing. Acknowledged a visionary, Block minimized day-to-day operational issues and paid less than close attention to the bottom line. One observer described Block's leadership style as "hands off. He thought in concepts, had his own agenda but often couldn't implement it. He had the vision, not the practical skills."

The faculty saw Block's COO as "tough" and "very forceful." "You had to create an agenda to meet with him," several administrators and members of the faculty complained about one aspect of his management technique. In coordinating the uniquely decentralized system that Heyssel had implemented and encouraged, the COO was attempting to transform a long-standing tradition at an institution where the culture changes only incrementally.

He left in April 1995, two-and-a-half years after arriving, a development that the *Sun* described as due to "policy differences . . . disagreement over how to coordinate the health system."[47,48] "His boss left him too independent and calling the shots," as one outside observer commented. "Fix the problems, and damn the torpedoes. They miscalculated the culture, and culture will always trump."

Block then brought the popular Ron Peterson from Bayview to the main campus as chief operating officer of the health system. However, the tenure of his first choice had hurt Block. The memory of the appointment—which Block recognizes as "one of my worst decisions, and I let him stay too long"[26]—lingered in the minds of many, reflecting, so they thought, Block's lack of understanding of the Hopkins way of life.

Johns Hopkins Medicine

Primarily because of the conflict between Block and Johns,[22] many aspects of administration on the medical campus had become dysfunctional, producing a state of affairs some called a "siege mentality."[16,34] "It was so horrible," said a senior member of the administrative staff, "that everybody recognized the need for something new."[49] And so, the trustees entered the case. "That

trustees were involved," remembers George Dover, director of the department of pediatrics, "told us there was big trouble."[22]

The leading trustees in what was to follow were the chairmen of the boards, Morris Offit for the university and George Bunting for the hospital and health system. Informed members of the faculty and administration considered Offit (B.A., Hopkins, 1957), the CEO of a wealth management private bank in New York, straightforward and willing to do anything for the school.[50] They saw Bunting, a private investor,* as a statesman but tough, a voice of reason and vision when passions were high.

In June 1995, after studying what the trustees called "every imaginable form of governance,"[51] the boards of the university and the hospital/health system decided to revise the governance of, and give specific functions to, Johns Hopkins Medicine, an informal collaboration created by the boards a year previously.[52,53] The purpose of the revamped Johns Hopkins Medicine was to "respond to the health care marketplace in an integrated way."[51] In addition, many hoped, the new structure would help to absorb the tensions between the managers of the medical school and hospital.[54]

In what would become the second of three iterations for Johns Hopkins Medicine, the organization would be led by a board of eleven trustees,[36] five each from the hospital/health system and the university, plus the interim president of the university, Dr. Daniel Nathans, as the nonvoting chairman. The university and hospital/health system boards would delegate to the Johns Hopkins Medicine trustees such medical center activities as budgeting, capital expenditures, contractual commitments, facilities planning, financing, strategic planning, and personnel.[55]

To carry out its duties, the trustees created, in June 1995, the "Office of Johns Hopkins Medicine" with the president of the university chairing the office.[52,56] They appointed to the office an equal number of leaders from the medical school and the hospital/health system, including Block, Johns, Peterson, Stobo, and the chairs of three clinical departments and one basic science department. To send a "cultural message" to the institutions, as the *Baltimore Sun* reported, the trustees instructed Block and Johns to "co-locate their offices† . . . and, where feasible, share support staff functions to ensure close

* Bunting had been CEO of the Noxell Corporation from 1973 until 1990, when Proctor and Gamble bought it. The company had been founded by his grandfather, who invented Noxzema skin cream.[46] During the governance change, in which Bunting played a leading role, the work at Hopkins consumed half of his time.[16]

† "Co-locate" was Hopkins officialese for sharing an office suite.

communications on a day-to-day basis."[52] The reporter added, "University officials downplayed the notion that the moves were linked to the conflict between Dr. Block and Dr. Johns."[52] Although most of his colleagues would not have agreed, Nathans stated that "personal clashes are not driving" the new organization.[56] As for the structure, he acknowledged that it "may look cumbersome at first blush," but insisted that the reorganization constituted a "major change" that gave the university president more authority over the Johns Hopkins health care system.[56]

The Office of Johns Hopkins Medicine then proceeded to meet weekly "to strategize about the whole medical campus," remembers Dr. Edward Benz, the director of the department of medicine and one of the members of the group.[57] At the meetings, both Block and Johns sat at the head of the table.[57] However, the "co-location" of the offices of the leading executives never occurred.

The scheme did not solve the fundamental difficulties. Describing the Office of Johns Hopkins Medicine as "a convenient, informal means of achieving strategic alignment," one of the hospital executives said, "it failed because neither side trusted the other, and the real problems never got to the table." George Bunting saw this version of Johns Hopkins Medicine as "a stopgap measure that I knew wouldn't work. Dan [Nathans] had no clout at the hospital, and this would require his spending much of his time in East Baltimore."[16] The whole enterprise struck Martin Abeloff as a "touchy-feely, midway solution" to the problems.[15] Walking to the hospital from a meeting in the medical school where the new structure of Johns Hopkins Medicine had just been described, one of Abeloff's colleagues said to him, "And tomorrow the Easter bunny will be here."[15]

Johns Resigns

Michael Johns had suggested that Hopkins create the position of chancellor responsible for all activities on the East Baltimore campus, including the schools of public health and nursing.[24] According to the *Sun,* Johns "hinted that he was the right man for the job."[52] Trustees told him, at the time, that a chancellor was "not the Hopkins way. A chancellor would not relate to the culture of Johns Hopkins Medicine."[52] Consequently, his friends were not surprised to learn, in December 1995, six months after the Office of Johns Hopkins Medicine had been formed, that Johns had accepted Emory University's offer to become executive vice-president in charge of the medical center

in Atlanta.[58] As one of his last official acts at Hopkins, Johns would hand a medical school diploma to his son and would then assume his new position on July 1, 1996.

Much as most faculty members regretted what Johns was doing, they thought they knew why the dean was leaving. Johns's colleagues saw him unhappy at Hopkins, in great part because of the constant battling with Block, and ready to consider another job. Morris Offit, the chairman of the university trustees, advised Johns to accept the Emory offer. "You'll never get a similar job at Hopkins because the hospital trustees won't approve you," Offit told him.[59] The intensity of his conflict with Block had so annoyed several of the hospital trustees who favored Block[39] that only by Johns's leaving could a solution to the problems of Hopkins medicine be achieved.[60] Concluding that he would "lose the war" at Hopkins, as one senior administrator put it, Johns proceeded to follow the advice of a friend among the department directors that "to become a president, you'll have to leave." Furthermore, when Johns decided to go, it was not clear that Hopkins would change its structure or that Block would leave.[61]

Emory had first approached Johns in August. "They came up here to visit me," Johns remembers, "and I went down there [to Atlanta] in October and over Thanksgiving."[24] He was impressed by what he found. Whatever his friends might have speculated about Johns's reasons for leaving Hopkins, he states that it was what Emory offered that convinced him to take the job. Emory had "an organizational structure and governance that I saw would allow me to achieve both my personal vision as well as the institutional vision of what a great health sciences center can and should attempt to be."[24] When Johns accepted the Emory job, he was also being recruited for a similar job at another well-known university.[24]

Johns's going was received as a "bombshell" by those on the campus not intimately aware of the details of the conflict[62] and with outrage by some of his closest associates.[50] It was "shocking,"[34] "tragic,"[18] a move that "woke everybody up,"[18] by causing "an imbalance,"[15,34] which could "tilt the balance of power toward the hospital."[14] "Nobody thought Johns was the problem except for Block and Baldy," one of the university trustees said.[60] Reflecting the anxiety of several of his colleagues, one of the basic science directors said that, with Johns gone, Block would "go his own way and could potentially endanger the academic side through his decisions." Another said, "We saw our clinical colleagues going nuts, caught between academics and what Block found neces-

sary."[42] Many members of the faculty agreed that the resignation of Johns "triggered"[63] the steps that followed.

With morale among the faculty falling[15]—"there was a sense the institution was going down the tubes"[44]—the directors of the basic science and some of the clinical departments decided to make the trustees aware of the gravity of the situation. They organized a meeting that was held on a snowy Sunday in January 1996, as the host remembers the occasion,[12] in the conference room of Dr. Charles Cummings, the director of the department of otolaryngology-head and neck surgery. "We saw the ship as rudderless," said Cummings. "Neither the school nor the hospital could serve its mission."[12] Most of the directors attended and drafted a letter to the university trustees. Although some wavered, eventually "a substantial majority"[12] of the departmental directors signed the letter.

In response to the letter, Bunting, Offit, and Nathans met, on January 29, 1996, with the department directors in the large room in the dean's suite where the advisory board holds its meetings.[25,64] With portraits of former deans staring down at them, the directors reviewed their dismay about the current state of the medical campus. Participants describe the session as measured, controlled, and cathartic, with "everyone behaving himself."[50] The department directors found the trustees "warm and responsive."

Most of the directors stated how much they regretted Johns's leaving and objected to Block's policies and to his manner of operating. Block's most eloquent supporter on this occasion was Paul McHugh, who said that the hospital president was ethical, that he had been unfairly treated, and that people were out to get him. McHugh's arguments, however, did not convince the others. Finally, Offit summarized that what he was hearing from the directors was that "Block has lost his moral authority." None objected to this analysis. In summing up, Bunting said that something had to be done about the governance.

The Trustees Act

After the meeting, Bunting made appointments to talk individually with each of the departmental directors.[16] He heard many insist that Block had to go, that he was the cause of the popular dean's leaving.[16] Bunting acknowledged to a reporter from the *Baltimore Sun* that the review about governance

in the medical center "was sparked by a near-revolt against Dr. Block by some senior medical faculty,"[65] but "I wouldn't be pushed."[16] Not all of the senior faculty, at the time, wanted Block to leave. Edward Miller had met with several department directors soon after Johns announced his departure and told them "we could not lose two leaders at one time." Miller admired many of Block's accomplishments while recognizing that "he did not always include others."[66] Rumors of Block's imminent departure caused Bunting to confirm, in a memorandum to hospital employees on January 31, 1996, that Block would continue in his job.[67]

Bunting reported to the members of the trustee committee on Johns Hopkins Medicine what he was learning.[16*] For some of them, the conflict was eye-opening. Eddie Dunn observed that "I didn't fully realize the great differences between the university and the health system before we met. It became clear to me that enormous power lies with the faculty."[54] Bunting also began discussions with the hospital and health system trustees about Block's future at Hopkins.[64]

Contributing to the political difficulties was the increasing financial pressure facing the medical school. Professional income generated by the full-time faculty had been, until recently, a leading source of money for the dean, but as the faculty's reimbursements decreased,[14] the school increasingly needed support from the hospital whose rates, unlike the doctors' collections, were sustained by the cost commission. With the clinical environment becoming so hostile, the basic science directors worried that the leaders of the hospital and health system would go their own way and make decisions that would adversely affect the academic programs.[14]

Deciding that "the squabbling must stop,"[68] the committee resolved to recommend to the trustees of the university, the hospital, and the health system that a truly unified organization must be created for the Hopkins medical

* This ten-member group included (titles at the time, if not stated elsewhere) from the university board Michael Armstrong, CEO of AT&T; Dr. Lenox Baker, a cardiothoracic surgeon from Norfolk Virginia; Michael Bloomberg; Morris Offit; and Shale Stiller, a lawyer and partner in the Baltimore firm of Piper Marbury Rudnick & Wolf. From the hospital and health system boards came Furlong Baldwin; George Bunting; Edward Dunn; A. B. Krongard, CEO of Alex Brown, the then local financial house; and Donald Shepherd, CEO of AEGON USA. Bunting and Offit co-chaired the group, and Robert Heyssel was the consultant.[68] "We really put ourselves into it," remembers Buzzy Krongard. "A fly on the wall wouldn't have known who came from which [university or hospital]."[69] Krongard thought working with the committee, "the most rewarding experience in the eleemosynary world I've ever had."[69]

enterprise, a system with greater consolidation than that which existed under Johns Hopkins Medicine.[70] Single leadership, it was hoped, should help to resolve more calmly the financial and other problems affecting the campus.[71]

The solution was not reached easily. Many of the committee's frequent[69] meetings had been intense and fractious.[54] Hospital partisans, particularly Furlong Baldwin, had long stressed their discomfort should the university and its officers dominate the hospital.[72] "I repeatedly said that we shouldn't redesign the structure, which had worked so well for 100 years, only because of people problems."[73] When, a few years previously, William Richardson, frustrated by the Block–Johns controversy, had proposed to the hospital trustees that the group discuss the possibility of a merger between the hospital and the university, Baldwin, feeling as he always did that "the university wanted to take charge of the process," replied, using his authority as the hospital chairman, "That's not on the agenda."[27] Baldwin continued pressing his point of view until another trustee "laid Baldy out," in the words of one of the participants, "and then things went OK." Heyssel helped bring Baldwin around by convincing him of the wisdom of consolidating under the university, thereby, for the first time in the history of the East Baltimore institutions, subordinating the hospital to the university.[59]

At its last meeting, the committee developed a unified solution after rejecting the creation of a separate chancellorship. Although this was the structure at many academic medical centers, the committee "didn't think we could sell a dean reporting to a CEO," remembers Bunting. "Too many layers."[16] If the chancellor reported to the university president, and the dean to the chancellor, then the dean's job would drop to two levels below the president and three levels below the university board. This scheme also raised the troublesome question about whether the chancellor should report directly to the board rather than to the president. The plan that the group eventually adopted featured, as a fundamental concept, the hospital and medical school under one leader of both entities, not so far functionally from the chancellorship that Johns, university trustee Michael Armstrong,[60] and hospital trustee Andre Brewster[74] had previously suggested.

The trustees worked quickly—"breathtakingly so," in the view of one basic science director[42]—and, by early in February, they announced the new plan. Johns Hopkins Medicine would be led by a large board of forty to forty-five members with roughly equal representation of trustees from the university and hospital boards. To further comfort the university, hospital trustee A. B.

("Buzzy") Krongard proposed that the university president should not only chair the sixteen-member executive committee of Johns Hopkins Medicine but also nominate the leader of Johns Hopkins Medicine,[16] provisions that represented important concessions by the hospital and health system trustees and acknowledged the university's central role in Johns Hopkins Medicine. Providing comfort for the health system and hospital trustees, Bunting and Offit reached an understanding that the chairman of the Johns Hopkins Medicine trustees would initially come from the boards of the hospital and health system.

The board of Johns Hopkins Medicine would create a new position, informally dubbed "czar," to whom, observers and the newspapers assumed, the dean of the school of medicine and the president of the hospital would report.[65] Later, the trustees decided that the senior executive of Johns Hopkins Medicine should also be the dean.[75] With the leader carrying the title "dean/CEO," a job description was delivered to the search committee.[14] "At this point in the institution's history," says Joanne Pollak, the general counsel for Johns Hopkins Medicine, "a title was needed for the leader which presented a coherent, single vision with power and focus."[53]* The new position would carry prestige and authority for its incumbent and clearly indicate that the university was the dominant partner.[30,69] "I said 'Eureka' to myself," remembers Morris Offit. "Making the title 'dean/CEO' is the heart of the restructuring."[30]

Since the trustees decided not to create Johns Hopkins Medicine as a legally constituted corporation, the organization came to be described as a "virtual corporation led by a virtual board."[7] It would function through custom, not from legal documentation, unlike the university, the hospitals, and the health system, whose boards have specific legal authority.

Meanwhile, opposition to Block's continuing as president of the hospital and health system was growing. Calling Johns the "sacrificial lamb," many faculty members believed that Block was responsible for Johns's leaving. It was rumored that an independent group of physicians was "trying to take over

* Historian and physician Gert Brieger questioned whether dean/CEO was the best title for the new job. "I thought it was wrong because we should deemphasize the CEO role."[76] The man who would become the first dean/CEO says his title has done that with the word *dean* coming first, emphasizing that scholarship in the medical school would dominate administration in the hospital and health system, at least in his office. Furthermore, if he were chancellor with a separate dean reporting to him, the faculty would relate primarily to his subordinate and not to him.[62] Eventually, Brieger gave up. "I couldn't think of a better title."[76]

jobs" at the hospital, and Block was assumed to be encouraging this. Johns's respected executive vice-dean, David Blake, was leaving with him, distressing the basic scientists of whom Blake was one. "So if Johns was going to go," Edward Benz, the director of the department of medicine, summarized the feeling of many, "Block had to go also,"[57] despite what Bunting had said in January.

Changes in the Dean's Office

Despite Johns's offer to remain at Hopkins until June, the instability of having a dean preparing to take a new job as he phased out of his current job led Daniel Nathans to appoint someone that winter to temporarily lead the school of medicine. On Sunday, February 11, 1996, Nathans met with Dr. Edward Miller at Miller's home and offered him the position of interim dean, effective March 1. Miller, who agreed to take the job, saw himself chosen as someone "without baggage, an outside-inside kid."[62] Miller had worked at Hopkins for only two years, having been recruited as director of the department of anesthesiology from the chairmanship of the same specialty at the Columbia University College of Physicians and Surgeons in New York City.* The clinicians liked his continuing to care for patients in the operating rooms, and, since he held competitive grants from the National Institutes of Health to support his research, the basic scientists accorded him respect. The department he led continued to be one of the country's largest[10] and most successful, its members receiving more money from the NIH than any other anesthesiology department. "My tickets had been stamped," he explains.[62] Miller had articulated a vision of how to deal with managed care and emphasized core issues as more important than transitory concerns.[22]

The interim dean faced a troubled environment. Nathans disapproved of the hospital administration's "cutting deals with the school locked out," felt that the hospital and the university were "picking sides,"[62] and believed that "a strong person" was needed "to protect the school of medicine."[66] Edward Miller remembers how "the hospital and health system were driving one way without much appreciation of what the school could add. Some on both sides

* Another candidate for the chair in anesthesia at the time was Michael Johns's brother Roger who, if he had been chosen, would report to the university provost to avoid his boss being his brother. "But it would have been awkward," Michael Johns acknowledges.[24] Miller would later appoint Roger Johns to succeed himself as director of the department.

couldn't talk to each other."[62] "Dan Nathans asked me, 'How did we ever get into this mess? Where is ethical behavior? How could Hopkins have fallen so low?' "[62]

This troubled time at Hopkins was blessed by the presence of Daniel Nathans, called "the heart and soul of the institution." In the changes to follow, Nathans's contributions, along with those of Bunting and Offit,* were seen as vital. Without Nathans, Offit believes, the change in governance would not have occurred. "When he said a change was imperative, we acted, trusting in his absolute integrity."[77]

As a Nobel Prize-winning basic scientist who had had clinical training early in his career, Nathans enjoyed widespread respect. He held Hopkins together during this tumultuous time in great part because of his moral authority.[57] "You just behaved yourself when with him," said Ed Benz. "He wouldn't allow Johns and Block to get too far out of line."[57] Modest and careful in what he said, Nathans liked to state, "I don't want to hear about personalities."[17] Thomas Kelly, who succeeded Nathans as director of the department of molecular biology and genetics (formerly microbiology),† knew him as "a phenomenal scientist gifted in many ways. His defining characteristic was his great judgment. The bloodletting would have been greater if someone like him wasn't here."[14] Nathans accepted the interim presidency reluctantly, but, as Kelly said, "he loved Hopkins so much that he agreed to do it." He once told Kelly, "The one thing that makes the job doable is that it will end."[14] When a new president arrived, Nathans planned to return to his laboratory.[78,79]‡

Block Resigns

In the beginning of August 1996, Block announced that he was resigning the presidency of the Johns Hopkins Hospital and Health System, a decision that pleased many members of the faculty. Block could not have favored the new structure in which he would have had to report to the dean/CEO of Johns Hopkins Medicine instead of directly to the Johns Hopkins Hospital board as in the past. Furthermore, since the specifications for the new job had come to

* Although based in New York, Offit seemed to spend two or three days per week in Baltimore while the institutions were seeking a resolution to their governance problem.

† In March 2002, Kelly left Hopkins to become director of the Sloan-Kettering Institute in New York City.

‡ Not long after leaving the interim presidency, Nathans developed leukemia and died on November 16, 1999, at the age of 71.[78]

include the incumbent's also holding the position of dean of the school of medicine,[75] Block knew that the job would not be offered to him. "I didn't fit," he recognized.[21] A hospital and health care administrator for most of his career, Block did not have the academic achievements expected of the dean of the Johns Hopkins University School of Medicine. "The bickering had to stop," he said. "If I'd stayed, it would not have worked."[21] And there were other reasons, Block believes. "Richardson had poisoned Morris Offit against me and had told Brody [Dr. William Brody, who would become the next Hopkins president] not to take the job if I stayed."[21] Furthermore, Block's great supporter, Furlong Baldwin, had been succeeded by George Bunting and was no longer chairing the hospital and health system boards. "As soon as Baldy was gone," Block realized, "I knew I was in trouble. After he left, it became a free-for-all."[26]*

The decision that Block leave, however, came from the health system board, not from Block. Despite his statements to the contrary, Block wanted to stay. Block explains his having to leave Hopkins because "I never found a way to work constructively with Mike, and I hired the wrong COO. I couldn't figure out how to make Mike look good so he was convinced I was trying to make him look bad. I didn't adequately manage the political environment, didn't do the dinners, hunting, and fishing, and I didn't have the faculty whom I could sit around with and build a political campaign."[8] Block later concluded that he would have done better by leaving earlier on his own.[8]

With the departure of Richardson and then Johns and Block, as a senior faculty member noted, "The three leaving cleared the slate." Richardson recognized this, saying, "The governance change wouldn't have happened so long as I was there because of the perceived power struggle. Jim and I were deadlocked. In many ways, my leaving was a significant contribution to Hopkins because they couldn't recruit a new president without dealing with the hospital issue."[28]

Ronald Peterson became acting president of the hospital and health system when Block left. In December, the hospital trustees confirmed Peterson as hospital president, the ninth senior executive since 1889. He would become president of the Johns Hopkins Health System the following February,[80] thereby becoming the first nonphysician to direct the hospital since 1946.† Heyssel had

* The respect between Block and Baldwin was mutual. "Baldy was a great board chairman and a great businessman," says Block. "Once he understood what I wanted to do, he supported me."[26]

† Although political scientist Steven Muller held the title of hospital president from 1972 to 1982, Dr. Robert Heyssel was, in effect, the senior on-site hospital officer.

hired Peterson, a former Hopkins undergraduate with a graduate degree in health care administration, in 1973 as an administrative intern and then appointed him administrator of the departments of psychiatry and pediatrics. Much admired throughout the campus for his abilities and modest character, Peterson had built a strong reputation leading and rebuilding the old Baltimore City Hospitals before and after the city sold the run-down facilities to Hopkins in 1984.[81] Although Block had brought him back to the East Baltimore Hopkins campus as chief operating officer of the health system in 1995, Peterson continued to hold the title of president of the Johns Hopkins Bayview Medical Center until 1999.

At Bayview and at Hopkins, Peterson was seen as attentive to detail and to day-to-day management,[82,83] and, without "the usual arrogance"[82] said to be characteristic of Hopkins faculty and doctors in general.[82]* As a trustee put it, "Peterson's a team player without the ego of Heyssel or Block"[68] and, as one of the senior doctors said, "He's learned medicine and understands that this place was built on research and teaching as well as clinical."[83] Accordingly, Peterson favors the appointment of faculty with potential for success in research, not only expert clinicians who would help to keep his hospital beds full.[18] This attitude brings him friends and supporters across Monument Street in the basic science departments. "He's a hero," says Jeremy Berg, director of the department of biophysics and biophysical chemistry. "As much as Block didn't fit into the culture, Ron does. With Ron, you can count on an agreement with a handshake."[42]

Peterson's senior associates, however, include no physicians. Dr. Myron Weisfeldt, who came to the chair of medicine at Hopkins from the same position at the Columbia University College of Physicians and Surgeons in New York City in 2001, had worked with doctors who constituted the top leadership at New York-Presbyterian Hospital, Columbia's principal teaching hospital.† He has encouraged Peterson to employ "a physician in hospital planning and allocation leadership to interpret the chairs' desires to the top people and help sort out what is the best opportunity."[85]

* "Yes, there's a tremendous arrogance there," acknowledges Steven Muller, but it's a "relentless arrogance" reflecting the excellence of the people working there.[84] "It's hard to be humble if you're at Hopkins," a senior professor said.[76] "There's an unspoken assumption about excellence so we don't need any 'coach talk' as I've heard at other institutions."[76]

† Edward Miller played an important role in appointing Weisfeldt to both positions, first as co-chairman of the search committee at Columbia and later as dean/CEO at Hopkins.

The First Dean/CEO of Johns Hopkins Medicine

By the end of 1996, Hopkins had two new presidents, Ron Peterson at the hospital and William Brody at the university. Brody, who had accepted the Hopkins presidency the previous April and started in September, was an old Hopkins hand.[86,87] A radiologist with bachelor's and master's degrees in electrical engineering from the Massachusetts Institute of Technology and an M.D. and a Ph.D. in engineering from Stanford, Brody had been director of the department of radiology at Hopkins from 1987 to 1994 before leaving Hopkins to become provost of the University of Minnesota's medical center. Michael Armstrong, who had known Brody when Armstrong was with IBM and Brody was developing a scanner with the company, strongly favored his election. "He's brilliant, can do research better than most researchers and write better than most writers."[60]

The problems on the East Baltimore campus had both delayed the presidential search[65]—although Richardson had announced at the end of 1994 that he would leave Hopkins,[32] Brody's selection was not revealed until April 1996—and contributed to Brody's election. John Lombardi, the Hopkins provost from 1988 to 1990, and then president of the University of Florida—"a popular choice," according to Offit[30]—chose to stay at Florida rather than become Richardson's successor,[88] in part, because he believed Hopkins "needed a university president who was in the domain of medicine."[89]

The governance change that would soon occur might "never have worked," Eddie Dunn, believes, "if someone other than Brody were president."[54] Even another M.D. who had not previously been at Hopkins or was known there "would have been at a material disadvantage. Only Bill could have instilled support from the faculty."[54] Trustee Shale Stiller agrees. "Everybody thought Brody as a doctor would help make Johns Hopkins Medicine work. He would calm the hospital people, while a non-doc would make the hospital people uneasy."[68] Brody was not, however, everybody's first choice. Some of the hospital trustees and members of the medical faculty did not favor having a physician as president.[30]

For several years after his appointment, Brody took an active role in East Baltimore[90,91] and, in a symbolic move, occupied Robert Heyssel's old office in the historic Administration (Billings) Building.[17] However, to allay anxieties at Homewood that the new president would be preoccupied with East Baltimore issues to the detriment of the nonmedical schools, Brody took his primary

academic appointment in the department of electrical engineering, the subject of his Ph.D., rather than in radiology. He avoided using his doctoral title, the custom of many who hold Ph.D. degrees unlike most physicians. Nevertheless, he shows his continuing interest in the activities of East Baltimore by writing an essay every two weeks for the in-house publication, *Change.*[19]

Meanwhile, Edward Miller was leading the school of medicine while awaiting the decision of the university and hospital boards about the first dean/CEO. Miller felt strongly that the proposed arrangement would be best for Hopkins and that the person selected, first and foremost, should have strong, well-recognized academic accomplishments, consistent with the title in which dean of the school of medicine came before CEO of Johns Hopkins Medicine. By the fall, Miller had decided he wanted the job, but saw the search committee "moving away from me because I wasn't an MBA-type."[62] Making it known that he was finding his job increasingly difficult to perform well in an acting capacity with only acting associates in the open positions, Miller pushed the committee and university president Brody to pick a permanent dean/CEO soon. "I couldn't walk out of the job," he remembers, "but I wasn't happy in it as acting."[62] Miller asked the departmental directors to force a decision and Ron Peterson to support him if he were appointed.[62] Peterson's backing was essential. The board and the administration trusted Peterson to run the hospital well if Miller, whose career had not included hospital management, were to become the ultimate leader.[92]

The search committee* met with leading figures in American academic medicine, who came to Baltimore as consultants but might convert into candidates. One was William Kelley, who put on an impressive slide show, explaining what he had accomplished at Penn. Kelley had reason to be optimistic about Penn's advances at the time and felt that the Hopkins people "viewed our approach as very good. We were gaining on them. They were looking over their shoulders at us."[93]

The committee, nevertheless, decided that what Kelley had accomplished for Penn was not what Hopkins needed at the time. "Our instability was in the hospital administration and not in the academic departments," as one mem-

* Members of the committee included Michael Bloomberg, Daniel Nathans, and Morris Offit from the university board; George Bunting, Edward Dunn, Dr. Nicholas Fortuin, a Hopkins cardiologist, and "Buzzy" Krongard from the hospital and health system boards; and department directors Edward Benz from medicine, Thomas Kelly from molecular biology and genetics, and Patrick Walsh from urology. Dunn chaired the group.

ber observed. The health system also did not have enough money to buy hospitals and practices as Kelley had done, and the internal ferment was preventing Hopkins from agreeing to Kelley-like purchases.[19] Kelley's reputation as a strong-willed leader alarmed the collegial Hopkins trustees and faculty who, remembering the recent conflicts between James Block and Michael Johns, shied away from someone "so potentially disruptive." They saw Kelley as a top-down manager who was unsuitable for the bottom-up, decentralized culture of Hopkins.[14] "Bill's checking the credentials of assistant professors would never have worked here."[14]

The job as leader of the nation's second most respected medical school and, according to one national survey, leading academic hospital, looked like a dream job. "You should take the best person in the world—it's a great job," advised Dr. John Rowe, then CEO of the Mt. Sinai Medical Center in New York City. However, the committee "never found that magical person from the outside," remembers Thomas Kelly, considered by former dean Richard Ross to be the "senior presence among the basic scientists."[72] "We needed someone," said Kelly, "who could run a $1 billion business well, had a distinguished academic career, and would fit well in our environment. There weren't many like this out there."[14]

In the midst of the deliberations, the university selected William Brody as president. "Tilt," Nick Fortuin remembers trustee Buzzy Krongard saying, "our job's over. Brody will decide."[94] Krongard adds, "I wanted Brody to at least have a veto. We were trying to avoid a fight."[69]

The search committee members, who never met any official candidates other than Miller and the consultants, realized that Hopkins now had an academic physician as president, "not a classicist," as one member observed. "Bill may not want to go up against a Kelley, Rowe, or Martin [Joseph B. Martin, then chancellor of University of California, San Francisco, and later dean of the Harvard Medical School]," said one of the trustees. Brody let it be known that he favored a nonconfrontational dean/CEO. This was a requirement that Miller would fill. Miller, who had made it clear that he wanted the job,[29,69] "walked in and made a successful pitch for himself," remembers Mike Bloomberg. "We might not otherwise have selected him."[29]

On January 12, 1997, the search committee met in the late afternoon. "I was told to be on call," Miller remembers about that tense period.[62] Two days later, Brody offered him the combined position of dean of the Johns Hopkins Uni-

versity School of Medicine and CEO of Johns Hopkins Medicine. Miller accepted. Hopkins's medical enterprise now had a chief executive very different from the previous leaders of the hospital and the medical school, a man who, according to one health system administrator, is "more focused on keeping the pieces together"[95] and, in the words of one of the hospital trustees, was "a solid citizen to take over the mess." The first dean/CEO of Johns Hopkins Medicine was, first and foremost, in view of the atmosphere in East Baltimore for the past decade, nonconfrontational.[2,19,29,34,69,85,96-98] He would not be a Hopkins version of Penn's William Kelley, which, many believed, Hopkins did not need. "It's quiet now [March 2001]," said Nick Fortuin, "like Bush after Clinton."[94]

Miller is a big man, 6′5″ tall with a deep and friendly voice, "a fortunate guy, in the right place at the right time."* Some saw his selection as a reactive or comfort choice, that, if he had not been acting, "he'd never been on the radar screen." From Brody's arrival in September 1996, the new university president found working with Miller and Peterson, who were both in acting positions, very smooth. As Buzzy Krongard observed, "The chemistry between Ed and Bill was very good, which says a lot about both of them."[69] This experience helped Brody make the atypical appointment for the new dean/CEO position by selecting the internal, interim executive over one of the external powerhouses who might have been chosen.† The campus was tired of rancor and would accept Miller, who came to the job with admirable personal qualities and "without much baggage."[69] He was also the devil everyone knew.

Since Nathans had appointed him interim dean the previous February, Miller was perceived as working hard and growing into the job. Unafraid of making decisions even while interim dean, he took on the two most powerful departmental directors of medicine and surgery and convinced them to give up their automatic seats on the governing board of the Clinical Practice Association during a restructuring of the practice plan. Faculty and staff appreci-

* Edward D. Miller. A.B., Ohio Wesleyan (1964); M.D., Rochester (1968); surgical intern, University Hospital, Boston (1968–1969); resident and chief resident in anesthesiology, Peter Bent Brigham Hospital (1969–1971); research fellow, Peter Bent Brigham Hospital and Harvard Medical School (1971–1973); director of anesthesia research, Brooke Army Medical Center, Fort Sam Houston (1973–1975); member of faculty (1975–1986), appointed professor of anesthesiology (1982), University of Virginia, Charlottesville; chairman, department of anesthesiology, Columbia-Presbyterian Medical Center (1986–1994); director, department of anesthesiology (1994–1999), interim dean (1996–1997), dean, (1997 to present) Hopkins; CEO, Johns Hopkins Medicine (1997 to present).

† Miller's appointment thereby broke one of the inconstant rules of medical academic politics: if you want the job, never be the acting.

ated Miller's ability to listen attentively and then integrate the information into his plans. Accordingly, as one faculty member said, "his gift as a leader is his ability to develop loyalty" by supporting his faculty and staff so long as he is kept informed. Miller quickly absorbed the local culture which, most of the faculty feel, eluded Block. Miller did this despite not being old Hopkins, since he neither attended the medical school nor trained in the hospital and arrived on the campus only two years before being named interim dean. He became a very effective cheerleader for Hopkins medicine, working crowds well, singling out individuals, and remembering facts about them and their families.

Six years into the job, Miller conveys a sense of confidence, and there is no question who is in charge. Not a micromanager and willing to share governance, Miller "is not breathing down one's neck all the time but lets people solve their own problems and only steps in when there's trouble." Appreciating that he could not reform the place overnight, Miller stopped the study of a scheme that would have led, if approved, to a basic change in the method of compensating the faculty, finding it too controversial to undertake at the beginning of a new dean's term.

"Peaceful" is the word most use to characterize the Miller regime. Calm has replaced turmoil partly because, in contrast to their predecessors, both Miller and Peterson are essentially quiet people. By avoiding petty bickering, Miller reaches for fair resolution of conflicts. He has become a leader who "requires low maintenance." Under the new arrangement, Miller, according to one of the basic science directors, "has the challenge of arguing with himself about the problems he faces. At least, he doesn't have to worry that his decisions will be countermanded."

Miller receives praise for recruiting new department directors, one of his most important jobs, "very professionally, very smoothly." During the first five years of his term as CEO/dean, Miller appointed sixteen department directors, and he will face vacancies in seven departments in the next two to three years.[99*] Conducting these recruitments successfully would have been very difficult during the height of the Block–Johns controversy.[100]

* By the summer of 2002, Miller had appointed new directors for anesthesiology, biomedical information, cell biology, biological chemistry, comparative medicine, dermatology, genetic medicine, history of medicine, medicine, obstetrics and gynecology, neurology, neurosurgery, orthopedics, pathology, pediatrics, pharmacology, and psychiatry. Future openings that he will need to fill include the directors of the departments of molecular biology, neuroscience, otolaryngology (ENT), surgery, ophthalmology, rehabilitation medicine, and urology.[99]

All is not perfect, however. Some see Miller so preoccupied by the CEO portion of his job that the dean's part gets shortchanged. "We have trouble getting the dean's attention," complained one basic science department director, "because he's so involved with managed care and the health system."

For two years after he was appointed dean/CEO, Miller retained the title of director of the department of anesthesiology and critical care medicine. Some thought that he did so to have a job to return to if he did not succeed in his new position. Such a maneuver is not unheard of in academic medicine. Miller explains that he needed to strengthen the department in order to present his successor with the best possible opportunity to advance anesthesiology at Hopkins and that he had excellent associates who could lead the department during this period. In 1999, the search committee recommended and Miller appointed Dr. Roger Johns, the brother of the former dean and a member of the Hopkins department, as the new director. Miller now says that "if I fail [as dean/CEO], I could not stay here."[101]

Miller delegates much responsibility to his vice-deans for administration, clinical practices, education, faculty, finance, and research. Each academic vice-dean works halftime in the dean's office and continues to function as a member of the clinical or basic science faculty, "the Ed Miller philosophy," as vice-dean for education David Nichols describes the part-time system in the dean's office.[102] Miller deliberately changed the character of these jobs from full-time to part-time to assure that the vice-deans would never forget that they are fundamentally members of the active faculty and to prevent their becoming academic administrators isolated from the day-to-day work of their colleagues. Even Miller has a nondean job. Most Tuesday mornings, he returns to his faculty role, dons scrubs, helps administer anesthesia, talks with his colleagues, and instructs trainees as he has done throughout his career. "If the dean has time to visit like this, he must consider the clinical work important. Frankly," adds Miller, "I do it because I love it."[101] Unlike many successful doctors in academic medicine, Miller is seldom away. "You mustn't travel much in this job," he warns. "You work for your faculty and your board."[101]*

The part-time arrangement for members of Miller's office, whatever the advantages the dean/CEO sees for it, does receive some criticism. The schedules

* Miller believes that one reason James Block was able to dominate the medical center was because Michael Johns was often away from East Baltimore, attending conferences and participating in professional societies and governmental agencies, the type of work that naturally flows to the dean of the Johns Hopkins University School of Medicine if he chooses to accept it.[101]

of the vice-deans are very full, and, consequently, seeing them quickly can sometimes be a problem for the directors.[103] Whatever the difficulties with the system, however, the deans being part-time emphasizes that, as Nichols adds, "this is a faculty-centric institution and requires that the dean take an active role as a member of the faculty."[102] Nevertheless, a faculty member who particularly admired the former dean says, "With Johns, we had a full-time dean with full-time assistant deans."

Miller is seen as "less hands on" than Johns. Some of the directors are concerned that Richard Grossi, the longtime chief financial officer of the medical school and, since 1995, of Johns Hopkins Medicine as well,[104] has become too powerful, making policy single-handedly and "scary to some." Some differ particularly with Miller's appointing associate or vice-deans who are department directors as he was once. "Their loyalties become divided," one director observed.

Despite these reservations, many of his colleagues see Miller now giving more of his attention to the academic mission. Soon after he started, "Ed tried to explain what managed care was all about to the faculty in the basic science departments," remembers Jeremy Berg. "The rank and file don't know and don't care. That's not why they get into the business. They want to hear about research and space. I think Ed now understands better what basic science is all about."[42] Describing the work of his faculty and trainees, Berg says, "Ours is a fairly monolithic life. It's less complicated than the life of a clinician."[42,79]

The New Organization

As Edward Miller converted from being interim dean of the school of medicine to permanent dean of the school and CEO of Johns Hopkins Medicine, he prepared to work within the new unincorporated governmental structure the university and hospital trustees had built. Johns Hopkins Medicine would now carry out the traditional missions of the medical institutions through a board of trustees that had just appointed a single executive to direct both the school of medicine and the clinical activities of the Johns Hopkins Health System. Four boards of trustees—for the hospital, health system, university, and Johns Hopkins Medicine—would still exist, but major authority would now be vested in the board and committees of Johns Hopkins Medicine.[62] The health system and hospital boards, for example, would no longer have executive, finance, or

facility committees, as the responsibilities of such groups were now performed by comparable committees of Johns Hopkins Medicine.

Despite its superior status, Johns Hopkins Medicine remains an informally constituted, not legally derived, organization. It is a mechanism that allows the Hopkins health system and medical school to conduct their work "with one voice in the marketplace," in Peterson's words,[105] without changing the formal structures established by the founder.

When it was formed, the board of trustees of Johns Hopkins Medicine consisted of fifteen trustees from the university board, fifteen from the health system board, and fifteen who served on both. The board would be self-perpetuating, with a nominating committee proposing new trustees, officers, and committee members for Johns Hopkins Medicine as well as for the boards of the health system and the Johns Hopkins Hospital. Five trustees from each of the three groups from which the original board was constituted comprised the initial executive committee.

Gradually, the size of the boards has decreased. By 2002, the number of trustees of Johns Hopkins Medicine had settled at about thirty-five. The Johns Hopkins Hospital board has thirteen members and the health system board ten. Five trustees from the hospital board and seven trustees from the health system board are also members of the board of Johns Hopkins Medicine. Although the trustees of the hospital and the health system continue to meet concurrently, the membership on the two boards has become increasingly different as the health system's functions have come to include more entities than just the Johns Hopkins Hospital. Only five trustees now serve on both boards.

The business of the medical school, hospitals, and health system is conducted by several groups. Most venerable is the Advisory Board of the Medical Faculty, established in the original documents creating the university. Since the founding, the university president or, in his absence, the university provost chairs the meeting with the president or provost and the dean sitting side by side at the head of the table.[61,103] The hospital president is always invited to the meetings of the advisory board. Unlike Robert Heyssel, who seldom attended,[76] the current president, Ron Peterson, is usually present.[18]

All members, if they are in town, regularly attend[103] the monthly meetings at 3:00 P.M., even though many describe the sessions as boring, the material rubberstamped and scripted with little opportunity to discuss matters. This is partly due to the size of the group. "The school had only fourteen departments

when I became department director in 1970," remembers Richard Johns.[106] "Now there are twenty-seven departments plus a cast of thousands so the meetings have become less useful."[106] Realizing that the group's size had become unwieldy as the number of departments grew, Richard Ross, when dean, created an "agenda committee" of six to eight members, also chaired by the university president or provost, which, acting as an executive committee, works out in advance the topics to be discussed at the meeting of the whole group.[72]

One attendee who found the meeting of the advisory board useful was William Richardson, who, as university president, chaired the advisory boards of each of the schools that constitute the university. "You take it seriously," he said. "The meetings weren't boring, rather they were inspiring and showed what it took to make the system work."[28] During the interregnum, when the university president and provost, the medical school dean, and the hospital president were all interim, the advisory board became effectively the ultimate internal authority in the medical center.[34]

Promotions occupy most of the agenda of the advisory board, "one of the most important things that keeps the place great," believes Brooks Jackson, director of the department of pathology.[107*] The review emphasizes to the senior faculty the quality of the faculty being promoted and helps to keep the level of scholarship high.[50] For several years William Agnew, director of the department of physiology, chaired the promotions committee. "The faculty's academic standards are truly stunning, exceptional. The candidates who come across the table for review define academic medicine, and define a flexible but high standard for being a Hopkins professor."[34] Only rarely are promotions rejected by the advisory board, that responsibility usually fulfilled by the promotions committee, which disapproves the advancement of about 15 percent of the candidates nominated by the departments.

All faculty in East Baltimore and at Bayview[107] are appointed and promoted in one track at Hopkins, which means that every faculty member is expected to meet similar criteria to advance. Most physicians in the clinical departments must perform at least some clinical duties, no matter how much the laboratory beckons.[107] To achieve promotion in the single-track system, every clinician must contribute to the research enterprise, and, of course, everybody must teach—and teach well. The emphasis on research is so strong at Hopkins that

* Jackson is the eighth director of the department founded by William Welch, first dean of the medical school.

junior faculty who spend most of their time taking care of patients often feel that they do not get the respect that their work deserves.[15] For this reason, among others, senior faculty continually discuss changing to a multiple-track system that provides a specific avenue for advancement for those whose work is principally clinical and educational, as is the case at many other schools.

Hopkins, so far at least, continues to preserve the single-track system which, in the opinion of one department director, is "almost a religious experience."[15] Most of the school's leadership believe that the one-track system best preserves the integration of science and patient care considered so important at Hopkins.[108] Perhaps one of the reasons the single-track system works is that different criteria are applied to faculty who do different jobs, an arrangement described as "a multitrack approach within a single-track system." A clinician, for example, is not expected to have published in the most competitive scientific journals as is each basic scientist but must demonstrate outstanding abilities that are recognized outside as well as inside Hopkins in his chosen field.

In addition to preserving the single-track system, the school of medicine does not award formal tenure. Rather, Hopkins uses what it calls a "contract to retirement" given to faculty members at the full professorial level. The contract seems to carry features similar to what is called tenure at most universities. The advisory board, which must approve the school's awarding contracts to retirement, is also charged to approve reductions of up to 20 percent per year in the salaries of permanent faculty members if recommended by the dean for those who can no longer support their compensation by clinical income or grants. This provision is seldom invoked. Those without contracts to retirement receive contracts for specific periods of time, often three years.

With the establishment of Johns Hopkins Medicine, the powers of the trustees of the Johns Hopkins Hospital and Health System diminished so that the principal purpose of those boards became the empowerment of the virtual board of Johns Hopkins Medicine.[7] The hospital board retained responsibility for credentialing the professional staff and certain other duties prescribed by the regulating authorities. Thus, the formal authority to direct the medical establishment which Johns Hopkins bequeathed separately to the boards of the university and the hospital is now exercised functionally by the trustees of Johns Hopkins Medicine and, at their appointment, by the dean/CEO. Although the boards of the university, hospital, and health system retain the authority of appointing the trustees of Johns Hopkins Medicine, in practice, the nominating committee of the virtual corporation now decides who will be trustees of the health system and the hospital.[109]

Over the years, few physicians have been hospital trustees. The governing board had long thought it inappropriate for the governed, in this case, the doctors, to have a dominating influence on the governance. Furthermore, regulations limited the number of physicians who could serve as trustees on the not-for-profit boards of hospitals.[110] Recently, however, more doctors have been added to the Johns Hopkins Medicine board.

The new Johns Hopkins Medicine board meets only four times per year compared with the schedule of eight meetings during each academic year of the Johns Hopkins Hospital board in former times. The relative calm during the meetings of the Johns Hopkins Medicine board reflects the delegation of many of its activities to its executive committee, whose chairman is the university president. Brody's sitting at the head of the table confirms that Johns Hopkins Medicine is centered in the university and not the health system or hospital and reminds everyone that the current dean/CEO was chosen by, and is responsible to, the president of the university.[109]

The formation of Johns Hopkins Medicine brought together, gradually in some cases, several administrative and financial offices that had previously operated separately in the medical school or in the hospital/health system. One department, however, which did not need to be restructured was communications and public affairs. "The public, our patients, and referring doctors, look on us as one," says Elaine Freeman, the executive director of the department since 1982. "To the outside world, the inside charts don't matter."[19] Freeman explains that there has been one public affairs office for the medical school and hospital for as long as she can remember. "We present one face to the public and the press and our internal audience even when we are having big troubles, unlike most academic medical centers where there are separate offices." Before Johns Hopkins Medicine was established, Freeman reported to both the dean of the medical school and the president of the hospital, and for many years, also to the dean of the school of public health, which now does its own public affairs.

The Hospital and Health System in the New Arrangement

Those interested in the administrative nuances of Johns Hopkins Medicine are well aware that the current president of the hospital and health system is not quite as equal as were his predecessors. Block, Heyssel, and those who went before them reported directly and only to their own boards. Now Ron Peterson reports to both the dean/CEO and the boards.[109] To formalize Miller's role as

Peterson's boss, the health system created for Miller the title of vice-chairman of the Johns Hopkins Health System Corporation. The vice-chairmanship allows Miller to hold the authority previously exercised by the president of the Johns Hopkins Hospital and Health System. Miller delegates the operating power to run the health system—which he can recover whenever he wishes—to Peterson, who reigns with the traditional title of president.[109] Although Miller's authority includes appointing and discharging the health system president, wisdom would require his obtaining the support of the board of Johns Hopkins Medicine and the university president for such a decision.

To emphasize his participation in the leadership of the virtual corporation that rules over the medical school and the health system, Peterson holds the title of executive vice-president of Johns Hopkins Medicine. Peterson is comfortable with the new arrangement. "I don't find it unnatural to report to the dean, a reasonable order of things in a research-intensive academic medical center, but," he adds, "other teaching hospital CEOs might not be so comfortable."[111]

Miller and Peterson respect each other's background and style.[112] Nevertheless, Peterson can never forget that he is number 2 in the hierarchy of Johns Hopkins Medicine. "Ron can have strong points of view, but, if Ed Miller disagrees, which has rarely occurred, Ron will adapt," says trustee Shale Stiller.[68] "If someone in Ron's position wanted to engage in a pitched battle, he'd be terminated. Because Ron is reasonable, no one deals with him as a subordinate, and the pitched battle will never occur."[68]

As for his day-to-day activities, Peterson says, "I'm 50 percent in Johns Hopkins Hospital business, but I spend a lot of my time with politics, external stuff, and health system policy matters. Judy's [Judy Reitz, the chief operating officer] the inside person."[111] As executive vice-president and chief operating officer of the Johns Hopkins Hospital, Reitz directs the hospital departments except for finance and human resources, which report to Peterson, and information systems as well as legal and public relations, which Miller directly supervises.[13]

Clinical Programs

"When managed care came to town by the early 1990s," says Harold Cohen, the first executive director of the State of Maryland's Health Services Cost Review Commission, "people feared that patients would be directed to hospitals that cost less than Hopkins," which had to charge more to cover uncom-

pensated care and the costs of operating the teaching programs. "But it didn't happen because most insurers here, except for Kaiser, don't insist that most patients go to cheaper hospitals."[113]

Nevertheless, Hopkins could not rely on its past reputation to keep its beds full and its clinics well attended. "We engaged in very aggressive marketing," acknowledges Edward Miller. "The sleeping giant woke up."[62] Miller credits part of the high census to "service excellence. We made the patient and health system family feel good, changed the ambiance, pulled out all the carpets. Like the Ritz-Carlton."[62] The hospital created a hotel-like service in the Marburg Building, one of the original, late-nineteenth-century hospital wings. For an extra $200 per day the patient who can afford to be pampered gets a luxuriously appointed room, nonhospital food delivered at nonhospital hours, and other amenities. Relatives can sleep in the patient's room.

Miller believes genetics and marriage help to account for his interest in these matters. "My dad was an employee benefit guy at Eastman Kodak, and my wife is in human relations." For the first time, Miller says, Hopkins made the experience of being a patient "our number 1 priority."[62]

Miller does not favor buying practices as a means of assuring an adequate flow of patients to Johns Hopkins. "First of all, we don't have the capital. We also felt that we would be devaluing our own family,"[62] a reference to problems Heyssel and Block had faced. Johns Hopkins Medicine, however, has invested in some external practices, buying 27 percent of the general medicine practice of a group of physicians in Ellicott City, an upscale suburb in nearby Howard County. Dr. Harry Oken, one of the senior members of the group and chairman of the department of medicine at Howard County General Hospital, remembers being approached by several other hospitals in the mid-1990s about selling his practice.[114] A not-for-profit hospital corporation offered $500,000 to each partner. Oken and his partners, however, concluded that maintaining control of their practice meant more to them than the large one-time payment. Accordingly, they were interested when Hopkins proposed buying a share of the practice. Hopkins also offered to consolidate administrative functions and to reduce such expenses as telephone rates and interest on loans by using Hopkins's borrowing power.[114]

"We were expected to wave the flag," said Oken, "and refer appropriate patients to the Hopkins Hospital."[114] This meant, for the most part, cardiology patients needing catheterization, which is usually performed at Hopkins by a cardiologist on the part-time faculty there whose outpatient offices are near

Oken's. When operations are required, a Hopkins surgeon usually does them. Previously, Oken and his partners had referred their patients elsewhere, sometimes to the University of Maryland Hospital, where Oken had trained as a medical student and house officer. An outstanding chief resident whom the medical school tried to recruit to the full-time staff, Oken still volunteers in the Maryland outpatient clinic, caring for patients and supervising the work of trainees. "I'm loyal to Maryland," he says, "but Hopkins gave us the best deal for our practice." Oken's decision did not please the Maryland hospital executives who had also wanted to buy his practice.[114]

Hopkins is pleased with the arrangement with Oken and his partners. "Buying into the practice created a linkage without creating a risk," says Rich Grossi. "The docs work for themselves. The value is in the relationship."[7] Since the hospital took only a minority ownership in the practice, the doctors continue to run the practice and have little incentive to settle back into the role of fully salaried employees. "We've aligned ourselves with a group of excellent doctors," says Peterson, and the hospital has secured a significant increase in referrals, particularly cardiology, as a result.[115] By not purchasing a majority of this practice or buying others, Hopkins seems to have avoided alarming local physicians about its potential to dominate, which could drive Howard County doctors to send their patients elsewhere.[115]

Hopkins Medicine also directs a group of primary care physicians—family physicians, general internists, pediatricians, and obstetricians—from the old Wyman Park Hospital group, the former Johns Hopkins Health Plan, and, more recently, Bayview Physicians.[116] All have been bundled together for administrative purposes into Johns Hopkins Community Physicians, a wholly owned subsidiary of the health system under the rubric of the Johns Hopkins Medical Services Corporation.[112,116*] This group of about 115 providers, consisting of ninety-five doctors plus nurse practitioners and physicians' assistants, staff the eighteen offices of the former Johns Hopkins Health Plan, including practices at Green Spring and White Marsh and other outpatient sites the health system has developed.[112] Most of the doctors are full-time employees of Johns Hopkins Community Physicians, and most of those who teach medical students and trainees have faculty appointments in the school of

* The hospital created the name "Johns Hopkins Community Physicians" because, as Ron Peterson explains, "it sounds less corporate than 'Medical Services Corporation'."[115] Peterson is chairman of its board, which consists of trustees who are internal executives, and the president and CEO who reports to him.[112]

medicine.[115] In only a few cases did the hospital and health system purchase the doctors' practices.

Johns Hopkins Community Physicians operates eighteen sites[117] for the care of about 150,000 patients, about 40,000 in fully capitated contracts. Many of the patients, representing the Hopkins commitment to provide medical services to the economically deprived residents in the East Baltimore area, are insured by Medicaid. The Department of Defense pays for the care of about 22,000 retirees and their families. This contract, which pays relatively generous rates, covers patients formerly looked after at the Wyman Park Hospital.

Johns Hopkins Community Physicians loses money, the inner-city practices the most. Although Hopkins is committed to caring for these patients as part of its mission from the founding, losses of this magnitude cannot be sustained indefinitely. The unit has and will continue to reduce the size of its medical staff and close or consolidate some of the low-paying practices that do not contribute directly to the care of patients in its East Baltimore neighborhood or to Hopkins's obligations for research and teaching.

Income generated by referrals, "downstream revenue," to the full-time specialists and the Hopkins-owned hospitals and home care unit—$133 million in 2001—helps to justify the losses Johns Hopkins Community Physicians sustains.[112] In addition, by providing convenient outpatient care, Community Physicians helps to unload the overcrowded and expensive emergency rooms at the Hopkins-owned hospitals and provides knowledgeable and timely help to its patients trying to maneuver through the complicated Hopkins system.

Because the Health Services Cost Review Commission regulates only hospital rates, Johns Hopkins Community Physicians brings more reimbursement to the hospitals than professional fees to the full-time doctors based there. Edward Miller, in his role as CEO of Johns Hopkins Medicine, supports the group. Wearing his dean's hat, however, Miller sees both advantages and disadvantages.[112] Although the Department of Defense pays his specialists well, Medicaid, for whom the cost commission does not set professional rates, pays doctors in Maryland poorly. The full-time faculty, accordingly, complain about the growing number of poorly insured patients they must treat while being pressured by the school's administration to generate more professional income. The other missions of the school, however, do benefit. The clinics provide opportunities to train medical students and graduate physicians and to conduct research.[112]

From the opening of the hospital in 1889 and the medical school four years later, the missions of the two have differed. While the Johns Hopkins Hospital, as directed by the founder, serves the health needs of its community regardless of the patients' financial resources, the medical school emphasizes education and research. The hospital's focus is predominantly local, while the medical school sees itself part of a national and international constituency. Conflict occurs as members of the clinical faculty, trying to fulfill their roles as physicians, also teach and, in many cases, investigate. Providing clinical care pays less generously than in the past,* and teaching seldom generates income. Opportunities for funding research, however, abound, particularly for those who carry the Hopkins label. The day is only so long, and many members of the clinical faculty find themselves torn by having to choose between supporting the clinical demands of the hospital and the practices and the academic requirements of the university.

Complicating the doctors' problems is the reluctance of the medical school to appoint additional full-time clinicians who could see the patients now clogging the waiting lists in several specialties. "The school sees everybody hired as a burden, a new mouth to feed even for replacements," says cardiologist Ken Baughman. "The atmosphere is one of belt tightening."[118] Division heads must obtain the permission of Rich Grossi in the Johns Hopkins Medicine Office to hire each new faculty member. In the past, approval by the department director would suffice.

Clinical Practice Association

One of interim dean Edward Miller's most pressing challenges was the shaky CPA, the Hopkins practice plan, which, like its counterparts at other medical schools, administers the financial aspects of the clinical work performed by the faculty employed by the school. Because of the high degree of departmental autonomy, a successfully centralized practice plan had not evolved at Hopkins.[119]

The practice plan constitutes one of the most important sources of income for the school of medicine, and, from time to time, the hospital had cast an acquisitive eye on this money. Dean Ross remembers the chairman of the

* For example, in 2001, Medicare paid surgeons $2100 to perform a coronary artery bypass graft (CABG) operation. In 1993, the insurer had paid $4300.[83]

hospital board phoning him at home one evening "to tell me in a rather casual manner that he had decided that the clinical practice plan should be run by the hospital in that it handled all the other financial matters associated with patient care and could do a better job than the school of medicine was doing with the billing." Ross was "furious" and objected so strenuously that "it never went anywhere."[120]

When he was appointed director of the department of radiology in 1995, Elias Zerhouni became, like the other chiefs, a leader in CPA. "It was a disaster," he discovered. "During 1995–1996, CPA collected 20 percent less than it had the previous year. I told Ed Miller, 'You're sitting on a time bomb'."[63] Miller, while director of the department of anesthesiology, remembers CPA as "eighteen chairs sitting around bitching about billing."[62] In approved administrative style, Miller put the complainer to work, naming him a vice-dean and president of CPA.

"Our first step was to pull CPA out of Johns Hopkins HealthCare and restore it to the school of medicine and to the departments," said Zerhouni.[63] His successor as president of CPA, Dr. William Baumgartner, adds, "The power base is still within the departments and probably won't change. It's what built Hopkins, the most decentralized hospital in the nation."[83]

Zerhouni spread out the leadership. Instead of automatically having the usual suspects on its senior board, Hopkins created a new board of governors of six elected directors and three nonchiefs chosen by the clinical faculty, each with term appointments. "No longer like the Security Council," says Miller, "with medicine and surgery automatically governors."[62] Zerhouni, who sees the Hopkins culture as decentralized, hybrid, with shared governance, "not command and control,"[63] arranged that young faculty members with untapped administrative talent staff the CPA committees on billing, contracting, finance and planning, and operations. "We needed people to speak for the whole faculty, not just for the departments they led."[63]

The chairs who were accustomed to dominating by virtue of permanent appointments complained, but Miller convinced them to come on board with the veiled threat that, if they did not, he would assign them the job of fixing the operation. "I don't think it's right for surgery," Zerhouni remembers John Cameron, the director of that department, saying, "but if it's right for Hopkins, I accept it."[63] Miller, who appoints the board president, selected Zerhouni first and then passed the job to Baumgartner, the chief of cardiac surgery, in 1999. The entire group of clinical chairs and administrators meet four times

each year with a representative director from the basic science departments participating and the dean, as chairman of CPA, attending.[63]

Once the system was activated, patients at Johns Hopkins Hospital received only two bills, one from the hospital and another from all the practices. Previously, each Hopkins department had sent a bill for its own services so that a patient who had had a surgical operation, for example, might receive a separate bill from his surgeon, anesthesiologist, radiologist, and internist as well as from the hospital.

In 2001, CPA collected $197 million, which represented 90 percent of net billings, an improvement from 75 to 80 percent previously.[119] Money arrived an average of fifty-nine days after the bills were rendered,[83] down from more than 120 days under the previous scheme. Operating the system costs about 9.1 percent of net billings, a figure that Kenneth Wilczek, executive director of the physicians practice plan, estimates, is at the 75th percentile among medical school practice plans.[119] Thus, the Hopkins plan costs somewhat more than at many medical schools, although, Wilczek adds, "I think our performance is generally better."[119]

The Clinical Practice Association, through its contracting committee, scrutinizes closely each HMO contract presented to it by the Office of Managed Care, which carries out the negotiations on behalf of Johns Hopkins Medicine. If the rates are egregiously low, CPA may advise rejecting the contract, and in some cases, this occurs.

After much debate, CPA established a noncompete covenant whereby all clinicians, upon leaving Hopkins, were prohibited from practicing medicine within twenty miles of any Hopkins medical facility for two years. The covenant, which went into effect on July 1, 2001, excluded from the restriction all faculty previously appointed, thereby grandfathering current clinicians, clearly an agreeable political compromise. The dean can relieve departing physicians of the restriction when he thinks it appropriate.[83]

Hopkins has not escaped the attention of the Office of Inspector General (OIG), which has reviewed 100 Hopkins charts looking for inappropriate billing for Medicare patients.[119] In February 2003, Hopkins agreed to pay $800,000 "to settle charges," as the *Baltimore Sun* reported, "that it submitted fraudulent bills to Medicare." The amount of this settlement pales in comparison with the $30 million Penn had to forfeit and the $8.3 million that the faculty group at the other academic medical center in Baltimore, the University of Maryland, paid to settle similar claims.[121]

Johns Hopkins HealthCare

With the departure of Jack Stobo, the role of Johns Hopkins HealthCare changed. Johns Hopkins HealthCare became a service and administrative organization with 300 employees, 175,000 members, or "lives" as they are called in the insurance business, and an annual administrative expense budget of about $30 million.[122] Johns Hopkins Medicine assumed much of the work that Johns Hopkins HealthCare had originally performed.[122] The medical center no longer needed a leader of Stobo's seniority and experience to direct HealthCare and negotiate between the dean and the president.[115] None of its future CEOs, who changed relatively frequently, would be physicians.

The external members of the board of trustees of Johns Hopkins HealthCare were absorbed into the board of Johns Hopkins Medicine, and an internal board consisting of Miller, Peterson, Grossi, Wilczek, and Joanne Pollak, the general counsel for Johns Hopkins Medicine and the Health System, directed the enterprise.[122] The corporation relocated from East Baltimore to less expensive suburban real estate,[122] a move that some said reflected its demotion in status and influence.

Johns Hopkins HealthCare continues to lose money despite earning income from administrative fees and from a Medicaid managed care group with which it participates. HealthCare, however, generates downstream revenue by helping to keep occupied with referrals the beds of Hopkins hospitals at the medical center and at Bayview.[122]

Funded half by the health system and half by the university as a physician-hospital organization, Johns Hopkins HealthCare provides "one voice for all managed care issues involving the system and the faculty practice," according to Denise Quandt, the vice-president for operations.[122] Not an insurance company nor holding a license as an HMO, HealthCare fulfills the role of a third-party administrator by providing the infrastructure and administrative support for managing insurance products, contracting, and claims on behalf of employers, the Maryland Medicaid program, and commercial risk contracts.[122]

Columbia Health Plan; Howard County General Hospital

For many years at Hopkins, the clinical departments have developed affiliations with community hospitals. To take an extreme example, much of the work in orthopedics, rheumatology, and immunology has been based at the

Good Samaritan Hospital, principally because of a lack of space for these services in the East Baltimore campus.[101] As Hopkins dabbled with creating an integrated delivery system (IDS)[116] in the early 1990s, James Block proposed more solid relationships, including mergers, with community hospitals. He was, however, never able to convince his trustees to invest the funds needed to realize his plans.

Nevertheless, after Block left, the new regime remained willing to listen to further proposals along these lines. One that reached the newspapers, in the fall of 1997, involved the Helix System of five local community hospitals.[123] A merger between Helix and Hopkins would have constituted the largest expression of the integrated delivery system concept that the medical center had yet undertaken. The deal fell apart,[124] accompanied by the resignation of the Helix CEO, who, it was said, "got ahead of his board" which ultimately did not support the merger.[101,125,126]

In the following March, Johns Hopkins Medicine announced the purchase of the Howard County General Hospital, a 233-bed facility in the planned community of Columbia, Maryland.[114,127-130] This was the second time Hopkins had owned Howard County.[131] In 1969, the Hopkins hospital and university and the Connecticut General Life Insurance Company had created the Columbia Medical Plan, a prepaid group practice modeled on the Kaiser system in California. The plan would serve the population expected to move into Columbia, then being developed by James Rouse, a Baltimore shopping-center developer.[132] Part of the project included building a general hospital and outpatient clinic for the patients in the health plan. According to the original planning, the hospital would accommodate only a few fee-for-service patients, then the predominant method of paying for health care, immediately raising potential conflicts with the community doctors who were not members of the plan.

Columbia was not ready for this version of what would later be called managed care, and by 1974, the health plan was having difficulties. Growth was slower and the costs of building and equipping the hospital greater than anticipated. In a community that lacked large employers who might choose the health plan for their employees, the plan, with only 5000 members, was sending few patients to the hospital. Even so, local physicians feared losing access to the hospital for their nonplan patients. Two other hospitals in the region threatened to construct branches in or near Columbia.[133]

At the medical school, "we ran into a buzz saw," remembers Robert Heyssel, to whom David Rogers, the dean at the time, had assigned the Columbia

project for which, Heyssel acknowledges, "I wasn't qualified and didn't know anything about it."[133] The Hopkins-appointed director at the scene wanted to employ community doctors, but the medical school refused. Whereas many faculty members in the school of hygiene and public health enthusiastically supported the effort, many academically inclined doctors in the medical school opposed it, wanting to keep Hopkins resources at home.[134*] Some faulted Hopkins for using resources to support the health needs of well-to-do suburbanites rather than those of the low-income residents of East Baltimore where the medical school and hospital were located.[133] Faced with these and other apparently insoluble difficulties, Hopkins decided to divest itself of the Columbia Hospital and transferred its ownership to a community board of trustees that would operate the renamed Howard County General Hospital.[132] The insurance company eventually absorbed the health plan, and Hopkins, wiser and somewhat poorer, departed from the enterprise. Heyssel, now leading the Johns Hopkins Hospital, had learned never to try to put the Hopkins name on something without the approval of, and under the control of, the department chiefs at the medical school. "I wasn't going to touch that third rail again," he pledged himself.† Summarizing the whole Columbia experience, he was forced to conclude, "It was the world's worst idea."[133] But it was only the world's worst idea then. Heyssel's idea would have its day later.[3]

By the mid-1990s, twenty years had passed since Hopkins had been involved in the Columbia Health Plan and the precursor of Howard County General Hospital. Managed care and HMOs now dominated how care was reimbursed. Howard County, which had become a successful, well-run[94] community hospital, was flourishing under local leadership. Nevertheless, the Howard County leaders were troubled. Alton Scavo, the chairman of the board, felt that the hospital's "financial situation seemed particularly unstable."[130] "We were just too small to realize our dream, too small to realize our strategic vision," its president, Victor Broccolino, told reporters from the *Baltimore Sun*.[127] To

* At the same time, Alfred Gellhorn was meeting resistance from faculty members at Penn to his desire that the medical school participate in improving health services to the community surrounding the campus in Philadelphia. Gellhorn and Rogers were trying in the late 1960s and early 1970s to involve their medical schools in activities that many at both Penn and Hopkins were not yet ready to support. The terms of both as deans in Baltimore and Philadelphia were relatively short, with Rogers serving only three years from 1968 to 1971 and Gellhorn six years from 1967 to 1973.

† Heyssel must have forgotten this pledge when he created a similar imbroglio over the doctors at North Charles and Wyman Park.

expand from the original fifty-nine beds, the hospital had become highly leveraged and could no longer borrow for the capital improvements and additional services its leaders and the community were demanding.[114] Although surpluses had grown under contemporary management, so had competition from both older and more recently built nearby hospitals, some with healthier balance sheets or better-established clinical reputations.

"The board asked me," remembers Broccolino, " 'where will we be in ten years?' They were thinking that we'd be forced into a merger, and that this was the time to do it," Broccolino felt, "when you're going up, not when you're going down."[128] Consultants had advised that, as the youngest hospital in the state with only a small endowment, Howard County faced a bleak financial future under its current structure.[114]

The hospital undertook what Broccolino called "a structured strategic planning initiative" led by a small group appointed by the board given the deliberately confusing title of the "Ad Hoc Provider-Collaboration Committee."[128] This team, pledged to conduct its deliberations in secret, consisted of the chairman and vice-chairman of the board plus two other board members, the CEO, and four physicians, including the president and vice-president of the professional staff. Two potential questions from a merger troubled all the board members. How much control over the direction of the hospital would the partner insist upon, and if control passed to the partner, how could the hospital's mission to serve the community's welfare be maintained?[128]

Twenty-two potential partners showed interest, including both academic medical centers in Baltimore, several community hospitals, not-for profit local and distant hospital-owning corporations, and for-profit corporations. Many of the local hospitals had few resources, and their proposals were received skeptically.[128] The group narrowed the choice to three finalists: a Catholic community hospital, a large Baltimore/Washington not-for-profit hospital group, and Hopkins. Each was offering more than $50 million. Joining with the sectarian hospital raised the issues of abortion and contraception at Howard County, "the home of free choice," as Broccolino described an important ethic in the community. Finally, someone asked, "Who is going to be here fifty years from now?" The members of the special committee were particularly impressed, as Scavo remembers, that senior members of the Hopkins Hospital Board "felt involved enough to participate in the discussions."[130] They also thought dealing with one dean/chief executive at Hopkins through Johns

Hopkins Medicine would be preferable to working separately with two chiefs at the hospital and medical school. The end of the turmoil of the James Block era was also seen as making Hopkins more attractive as a partner.[130]

"When the smoke cleared," according to Broccolino, "Hopkins looked best."[128] The Howard County trustees insisted, however, that the sale had to benefit their hospital. The terms that were negotiated satisfied the Howard County trustees, and, accordingly, as Al Scavo remembers, "the board sold the hospital on its twenty-fifth anniversary—rather unsettling in my mind."[130]

Meanwhile, some of the more vocal members of the professional staff worried that local problems would be ignored within the immense Hopkins empire. There had been a long history within the region's professional community of estrangement from Hopkins, from which few of the practicing doctors had graduated and whose pride had long irked many. Several Howard County physicians, particularly the specialists, feared that Hopkins would try to displace them with full-time doctors from East Baltimore, and some refused to believe Hopkins when its executives said this would not happen.[114] To help allay their anxieties, Hopkins offered the Howard County doctors a formal link to its faculty and facilities in East Baltimore without interfering with the organization of its medical staff and guaranteed to keep its hands off most of the operations. "We knew," as Richard Grossi explained, "that they knew better than us how to run the place and deal with the community."[7] Howard County enthusiast Al Scavo adds, "They'll allow us to remain what we are, a community hospital."[130]

The purchase would eventually cost Johns Hopkins Medicine about $140 million,[127] although no cash was, or would be, transferred from the resources of the center in East Baltimore, a condition for the purchase that the Hopkins board insisted upon. Instead, Hopkins would add the community hospital's $55 million debt to its own debt and, through sale of additional bonds at the preferred rate Hopkins could obtain, provide $45 million over a five-year period for capital improvements. To raise the capital that the Howard County trustees insisted Hopkins contribute to fund a foundation to be created by the current Howard County board for local health care needs, Hopkins assumed new debt and Howard County contributed $17 million from its cash reserves.[115,127] After the merger, the community hospital could draw on Hopkins's working capital for short-term operating needs. The principal and interest for the Howard County portion of the new debt carried by Hopkins would

be paid from surpluses the community hospital pledged to develop. To assist this process, Hopkins would provide administrative and clinical expertise.[115]

Howard County retained its name with the addition of the Johns Hopkins Medicine logo to its stationery and signs.[135] Although Hopkins agreed that ten of the fifteen members of the Howard County board would be local residents unassociated with Hopkins,[135] it was clear who now owned the hospital. Hopkins would determine financial issues at Howard County General Hospital, with the local board continuing to credential the professional staff and supervise quality control over the hospital services. The CEO would serve at the pleasure of the president of the Johns Hopkins Hospital and the dean/CEO of Johns Hopkins Medicine. The Howard County board retained the right to approve the appointment of future CEOs nominated by Hopkins and could recommend that its chief executive be fired.

In addition to providing the financial support the hospital needed, Hopkins also offered several additional features that held considerable appeal to the doctors and trustees. First, there was what Victor Broccolino calls the "halo effect," which many, although not all, felt about associating with Hopkins. The medical center also provided professional oversight to improve the function of several services such as the emergency department, obstetrics and gynecology, and pediatrics.[115] Hopkins-assisted administrative changes further improved the hospital's finances.

The chairman and vice-chairman of the Howard County board would serve ex officio on the board and the executive committee of Johns Hopkins Medicine and the president of the medical staff on the board of the Johns Hopkins Health System. These arrangements helped to dampen the concern that Hopkins would ignore the issues of greatest concern to the Howard County doctors, staff, and trustees.

In explaining why Hopkins did what it did, Edward Miller said, "We are not in the business of going out and buying community hospitals, but they put themselves up for sale, and it was an important strategic opportunity for us."[127] Hopkins needed a presence in the area, with its "exploding population"[114] of well-insured patients and only one general hospital.[115] Buying Howard County, Hopkins concluded, should prove less risky than creating another Green Spring Station facility there or buying local practices.[7]

The purchase was also partly defensive.[7] Hopkins wanted to prevent the University of Maryland Medical System or St. Agnes Hospital,[94] both closer to

Howard County than Hopkins, from obtaining this attractive facility in a community of well-insured, relatively wealthy patients. Hopkins needed to protect from going elsewhere 300 of the annual admissions referred by the Howard County physicians.[7] Since the purchase, the number of referrals from the Howard County General Hospital to the Johns Hopkins Hospital has doubled.[114]

"We became a player," said Grossi. "We acted swiftly which we couldn't do before. We became a force because we cut a deal. The insurance companies had more respect for us."[7] According to Peterson, Howard County is "doing better than ever"[115] and is exceeding the financial status Hopkins projected at the time of the purchase. Eventually, Hopkins may want, even need, to send some of its students and trainees to Howard County for part of their clinical education. "We may not be able to depend forever on our East Baltimore facilities," predicts Peterson.[115]

On the local scene, Harry Oken has found the process "very smooth. There's lots of happiness."[114] That was it, however, and, as of the summer of 2003, the health system has not purchased any more hospitals.

Physician Groups

One of Edward Miller's most important tasks as Hopkins's first dean/CEO was to assure that enough patients entered the Hopkins system to train students, to conduct research work, and to keep its hospitals afloat. One of the forces opposing this aim in Baltimore was Midatlantic Cardiovascular Associates, which would come to dominate the practice of cardiology and referrals to cardiac surgery in the community. Several doctors in the group had been members of the Hopkins faculty and went into private practice for the usual reasons: more money, concern as clinicians rather than investigators about getting promoted at the medical school, and the desire to control their practices and their professional lives more directly.[118]

"Cardiology's no longer tertiary," says Dr. Stephen H. Pollock, a founding partner of Midatlantic, whose members practice privately at several local hospitals.[136] Most of the procedures and operations performed by the cardiologists at academic medical centers can now be conducted equally successfully by well-trained cardiologists working in the community. What was missing in the professional lives of the community cardiologists, until Pollock and his associates formed their group, was a mechanism for them to assure the flow of

patients insured by the HMOs. "We saw Hopkins as our principal competitor and the HMOs as the enemy."[136]

Pollock and a few colleagues formed Midatlantic in 1994 by merging their own small group with three other groups of heart specialists. By 2002, the partnership had grown from nineteen to fifty-five cardiologists who work at offices based where they were located before they joined the group.[137] Now large enough to bargain competitively, Midatlantic has 320,000 lives under capitated contracts through three insurance companies.[138] The group is governed by a board of directors consisting of representatives of the geographically distributed groups. However, a nonphysician CEO and his staff conduct most of the administrative work and strategic planning. "Docs are stupid doing business though they think they can do it," Pollock has found. Consequently, "we don't have a managing partner. Our head administrator's an MBA."[136] The fourteen-member board tends, at least so far, to perpetuate its current members, "for continuity" Pollock says, although he recently stepped down to allow a colleague to join who wanted to participate in the board's work. A graduate of the University of Maryland School of Medicine and its training programs, Pollock can now practice his specialty, with the business side of his practice handled by professionals and his colleagues on the board.[136]

Of the doctors in Midatlantic who are partners, each participates equally in the earnings of the group regardless of whether the doctor performs the more highly remunerated procedures such as angioplasty or electrophysiology, in which patients are given pacemakers and implantable cardioverter-defibrillators. The annual income of each partner is $350,000 to $400,000, "but each of us works very hard for it," adds Pollock.[136] Most new members of Midatlantic now join as associates and must expect to work up to seven years before being invited to enter the partnership. Their starting salaries range from $135,000 to $150,000 per year. A few doctors in the group are salaried employees on a "nonpartner track." These are usually older doctors who do not want to work as hard as the partners or cover the practices on weekends, nights, or holidays. The partnership allots to each member the maximum allowed for contribution to the retirement program and other financial benefits. There is little time for research, although the group does participate in drug studies; few members can find time to teach students or trainees.

Midatlantic, Pollock says, now includes most of the practicing cardiologists in the region who are not based at Hopkins or the University of Maryland.[136] "With about 22 percent of the doctors, we did approximately 50 percent of the

interventional cardiology [cardiac catheterization and electrophysiological studies] in town during 2001," according to Hank Yurow, the group's administrator.[138] Pollock and his colleagues recently added cardiac surgeons to the group, five by 2002, who earn the same amount as the cardiologists even though some could make as much as $700,000 in a busy private practice in the Baltimore area. "Medicare and the HMOs are forcing down their fees substantially, so working with us and being assured of lots of referrals makes sense. Of course, the surgeons to whom we now refer will get fewer cases," the competitor in Pollock adds,[136] and, accordingly, some of them are suing Midatlantic.[49]

Midatlantic was not the only group of physicians in the Baltimore area that was trying to meet the challenges of managed care in the 1990s. Flagship Health was another with which Block, Stobo, and his successors held discussions.[41,139,140] This large group of general internists and pediatricians suffered the fate of many similar physician groups that sold their practices to, and became employees of, organizations that promised to help them obtain managed care contracts and practice more efficiently.[141] Hoping to reap the returns when the management company went public, the doctors accepted stock rather than cash for their practices. The management company failed,[142,143] and the doctors had to buy back their practices with the company retaining their accounts receivable. The stock became worthless.[144]* "The experience," says Ira Fine, a busy rheumatologist-internist based at Green Spring, "taught us there's room for smallness. Everything doesn't have to be Home Depot. Now we're doing OK."[144] The talks between Flagship and Hopkins, which Stobo and his staff hoped would lead to joint participation to obtain managed care contracts,[41] never got past the "warm and fuzzy stage"[140] and led to no meaningful link between the group and the hospital. As was so often the case in such dealings, the practitioners were suspicious of Hopkins's motives and thought they could do better on their own.[41]

Somewhat less dramatic were the negotiations with Clinical Associates, the largest group of internists and specialists in the area.[41,145] Block, according to Stobo, wanted to acquire the group, and he and Joanne Pollak negotiated for several months with the leading partners in the group. "It never felt right," said Stobo, and, eventually, the hospital board killed the project.[41] Stobo describes the episode as "part of the frenzy of the mid-1990s that bigger was better."[41]

* Dr. Michael Rudikoff, one of the partners in Flagship Health who participated in the negotiations, observed ruefully, "I concluded there is no business in the management of doctors."[140]

Education

Since the educational mission at Hopkins has always been primarily a medical school function, teaching was little affected by the Block–Johns controversy or the development of Johns Hopkins Medicine.[45,100,102] Medical students, referred to as "undergraduates" as far as the school is concerned, do most of their work in the first two years in the basic science departments, and, although much of their clinical training in the third and fourth years occurs in the hospital, the clinical departments direct these experiences and the hospital administrative staff is little involved. Similarly, continuing medical education (CME) courses to acquaint trained physicians with the latest developments are taught by the faculty and administered by the school and the departments.

The greatest interaction occurs at the level of the interns and residents because these recently graduated doctors spend most of their time caring for patients admitted to the hospital or visiting the outpatient clinics. Unlike at most academic medical centers, the 680 Hopkins house officers receive school of medicine, not hospital, paychecks.[100] The hospital reimburses the school for 90 percent of this cost. The next stage of physician training, the clinical fellowships, however, is principally funded by the divisions and department in which the fellows work. Of the 300 clinical fellows, only 10 percent are supported by the hospital. Whenever a new clinical director is recruited, one of the topics of discussion is how much of the cost of the trainees the hospital will cover. This is the time when the hospital may increase its participation so that both entities can convince the candidate to take the job.[100]

Each year, Dr. Beryl Rosenstein, vice-president for medical affairs at the hospital, and Dr. Levi Watkins, associate dean for postdoctoral programs at the school, recommend how many house officers will be employed and what salaries and benefits to pay them.[100] They then jointly present the budget for these expenses to Johns Hopkins Medicine chief financial officer Richard Grossi. David Nichols, the vice-dean for education, describes the activity as "friction-proof and very smooth," thanks, in great measure, to the presence of the single administrative structure.[102] "It's realistic, no longer contentious," adds Rosenstein.[100]

Ron Peterson, the president of the hospital and health system, although not a physician, constantly supports the educational role, and, to indicate his interest, attends the graduation and other ceremonies related to Hopkins medical education.[102]

Philanthropy

With hospital surpluses limited by the rates set by the Health Services Cost Review Commission in Maryland and physician compensation dropping, Hopkins as well as other academic medical centers have increasingly turned to philanthropy for the capital needed for hospital and medical school buildings and to support research. In the past, the umbrella under which all fund-raising was conducted, according to John Zeller, associate vice-president of the Fund for Johns Hopkins Medicine, "operated very much in a reactionary mode with the majority of the support coming from familiar donors, corporations, and foundations."[71]

Zeller's group now includes eighty-five employees who raised $160 million in the 2000–2001 academic year. The development program costs annually $7.5 million, which includes its portion of the costs for those departments that have hired their own development officers. As for performance, as Zeller puts it, "we expect the same productivity of our development officers as the dean and directors expect from the faculty."[71]

Most donors, who give personally or through foundations they control, have either been patients at Hopkins or are related to those who have been. As a general rule, their affiliation is with the faculty member who treated them rather than with the institution or senior officer like the dean/CEO. Consequently, these donors tend to support their doctors' departments and divisions, a pattern that the decentralization characteristic of Hopkins encourages.[14] The money may be assigned to pay for the costs of research or support the salary of a physician-investigator who can then spend more time in his laboratory and less developing income from practice. Increasingly, donors without previous Hopkins affiliations give because of a particular interest in a disease and concern about the genetic implications of some ailment for them or the members of their families. "The Internet is very helpful in this respect," Zeller says. "They dig deeply and find out where the most exciting research is going on. Fortunately, that sometimes means Hopkins."[71]

Before Johns Hopkins Medicine was established, these donations could lead to controversy with executives and trustees more oriented toward the hospital. "I clashed with Ross from time to time who felt that it was the doctors who brought in the money, not the hospital," said longtime hospital trustee, attorney Andre Brewster.[74] When the patients of leading clinicians made contributions, the money flowed to the school, not to the hospital, since it was usually given in the name of the doctor, a faculty member.

The creation of Johns Hopkins Medicine and its single dean/CEO has simplified Zeller's work. When he started at Hopkins in 1995, Zeller reported to three people: the vice-president for development at the university, the dean of the school of medicine, and the president of the Johns Hopkins Hospital and Health System. "I served three masters with different priorities," says Zeller.[71] During the Block–Johns period, "a very difficult time," Zeller remembers, the department had difficulty negotiating priorities and making plans to reach potential donors. Although the media's coverage of the conflict caused problems selling Hopkins's story locally, grateful patients and foundations continued to contribute. "I flew under the radar screen, kept my head down, and avoided being shot," Zeller remembers.[71]

Now his bosses are Miller and Robert Lindgren, the university's vice-president for development and alumni relations. Competition between the hospital and the medical school for development support, a major problem in the pre–Johns Hopkins Medicine days, is now resolved in the office of the dean/CEO. A logical formula dictates where the donations are assigned. Money donated for research, whether it is given to the hospital or the school, goes to the medical school, whereas funds donated for patient care go to the hospital. "The donor's intent is paramount," Zeller says. "Most of the gifts are given for disease-specific research because of the kind of place we are. It's more difficult to identify bricks and mortar people."[71] Zeller's office is also responsible to raise money from the 5500 living physician-graduates of the medical school and from those who have obtained Ph.D. degrees or trained in the hospital as house officers and fellows. "They tend to support basic science and scholarship."[71]

The development office is now preparing a new campaign for Johns Hopkins Medicine. About $225 million will be assigned to capitalize another basic science building for the medical school and, for the hospital, a new children's center and a building for the care of critically ill patients. The remainder will be assigned to the school and its departments and divisions to support research and teaching through endowments, which will generate named chairs to support faculty salaries and equip laboratories and offices.[71] The dean/CEO participated actively in the work that preceded the campaign. Zeller and Miller spoke with each department director and, armed with appropriate data, asked them, "what do you need?" The total came to $900 million to $1 billion, and that is what the new campaign will try to raise. As for the development work itself, Zeller finds Miller a very effective fund-raiser. "He's marvelous talking with people."[71]

Death of a Research Subject

In June 2001, Hopkins reported that a previously healthy young woman had died from the effects of inhaling a drug being evaluated in a study of asthma.[146,147] Adding to the tragedy, the subject was employed by Hopkins as a research technician in a laboratory at Bayview and was well known by many workers there. Agencies and committees of the federal government, finding that the investigators had not sought or received approval to administer the unlicensed drug used in the study,[148] faulted Hopkins's system for evaluating clinical research and temporarily halted almost all research involving human subjects at the school.[149] After Miller "angrily," according to a report in the *Baltimore Sun*,[150] defended the institution's safety record, the federal Office for Human Research Protections (OHRB) lifted the restriction. It was clear, however, that Hopkins would not resume many similar studies until medical school and governmental groups had carefully reviewed the research protocols and practices.[151]

The death, which received national attention in the media, challenged the new administration. Under the structure of Johns Hopkins Medicine, one person, the dean/CEO, was now responsible to make decisions that would protect the entire Hopkins medical establishment during a very trying period. Assisted, in particular, by health system president Ron Peterson, Edward Miller could direct a collegial and effective response.[152]

The seriousness of the episode, widely recognized throughout the institution,[85] brought university president William Brody to East Baltimore frequently[2,91,152] to participate with Miller and his colleagues in developing and revising policies to prevent such an event from recurring. Although Brody's being an academic doctor had engaged his professional interest in the crisis,[91] such participation in important developments in East Baltimore had been characteristic of the university leadership since the medical school opened more than 100 years ago.[152]

A New Corporation for Johns Hopkins Medicine?

Although Andre Brewster saw the final structure of Johns Hopkins Medicine as "a halfway measure" and wanted to create a new corporation—"I never saw a corporate form I didn't like as a concept,"[74] the corporate lawyer says—most leaders on the campus think the current virtual and unincorporated

structure of Johns Hopkins Medicine is working so well that no substantial revision seems necessary.

Although one executive now has the authority to direct both medical school and hospital, the leaders rejected merging the Johns Hopkins, Bayview, and Howard County hospitals and the medical school into one corporate entity. In addition to the weight of tradition and history,[63] several practical considerations interfered with bringing form completely into agreement with function:

- Creating a single medical staff. Currently, the criteria for physicians to join the hospital staffs differ among the constituent hospitals. For example, most physicians admitting to Johns Hopkins Hospital hold faculty appointments at the medical school. This might be counterproductive if a feature of staff privileges for all doctors at Howard County General Hospital.
- Creating a single license for the combined hospital. Currently, each hospital has its own license. A single license would require combining different medical and administrative operating procedures in each of the hospitals to meet a common standard for the Joint Commission for the Accreditation of Health Care Organizations. (JCAHO).*
- Consolidating the debt rating for each hospital into one rating. This could lower the rating at the Johns Hopkins Hospital, which currently has the highest rating of the three, thereby strengthening the credit of some while weakening the credit of others.
- Combining the endowments, pension plans, union contracts, and arrangements for handling risk.[63,154] Providing benefits for hospital employees similar to those enjoyed by university employees would, in trustee chairman Edward Dunn's words, "bankrupt the institution."[54] University employees, for example, receive superior retirement benefits, which the health system could not manage to duplicate for all employees.[54,68]
- Losing one major gift. The Harry and Jeanette Weinberg Foundation, whose funds contributed greatly to building the cancer clinical center, cannot, according to one of the founder's provisions, donate to universities.[68] Creating a separate corporation into which the university would transfer the medical school to avoid this problem proved as unlikely when Johns Hopkins Medicine was established as

* Which was necessary in the merger of New York and Presbyterian hospitals in New York City.[153]

an unincorporated entity as it did in 1989 when proposed by former dean Richard Ross.

— Maintaining the right of each entity to withdraw from the consolidation. Incorporation would make such action more difficult[68] and increasingly more unlikely as the university and health system leaders see that two apart would be less strong than two together.[109]

— Protecting one entity from a financial debacle at the other. This option never became a major consideration as the restructuring proceeded. "We knew," says Joanne Pollak, "that by making a virtual corporation, we were pledging that one would not abandon the other. Our fates would be inextricably entwined."[109] Nevertheless, maintaining the separate corporate structures for the two entities has important effects. The bond rating agencies continue to evaluate the university and health system individually, and the endowments have not been combined, nor was there any effort to do so by 2002. In the 1980s, the hospital had created a separate corporation for its endowment. Under regulations, this independence allows only the annual income of 5 to 7 percent of the principal to be reported and to be considered when the HSCRC makes its determinations.[109]

— Finally, creating an official and legal structure for Johns Hopkins Medicine that would involve transferring the school of medicine into a new corporation. This undertaking would leave the university with a relatively small undergraduate and graduate school of arts and sciences and specialized schools of business, education, engineering, international studies, music, nursing, and public health. Hopkins would no longer include its most renowned entity. With half of the university's budget disappearing, Hopkins's credit rating and its standing among the elite of American institutions of higher learning would suffer.[109]

Although further fundamental restructuring seems unlikely, certain anomalies between policies of the university and health system may come to resolution. To the extent that it is economically feasible, the leaders would like to make more equal the terms of employment among all employees in the medical school and in the hospitals and health system. They continue to look for ways of dealing with such an issue and avoid the wrenching changes that would accompany establishing a separate corporate structure for the otherwise well-

functioning Johns Hopkins Medicine.[109] Nevertheless, in the opinion of chairman Eddie Dunn, "the virtual system's working as well as if it were incorporated, but it's dependent on the people working together. A system's only best at the time it's best. Someday, it will change."[54] One should remember, moreover, that Johns Hopkins Medicine could disappear whenever the university or health system board should so decide.

Was the Block–Johns Controversy the Cause?

Would the change in governance have occurred without the turmoil that developed because of the differences between James Block and Michael Johns? Opinions differ. Many doctors, trustees, and administrators think that, without the conflict, there would be no Johns Hopkins Medicine or that any change in governance would be a long time coming.[6,12,14,29,39,59,69,94,96,97,101,155,156] Several trustees held to this point of view: "If they'd gotten along, it might have continued to work" (Mike Bloomberg);[29] "The people pushed the issues to the forefront. We would have talked about a different structure but might not have done it if the leaders at the two places were getting along" (George Bunting);[16] "The place fell apart because of personalities. Creating one corporation was a reactive choice to all this" (Nick Fortuin);[157] "Block made two great contributions, Green Spring and the current structure which he forced to happen" (Edward Halle);[156] "If Brody, Peterson, and Miller had been in the jobs, the change wouldn't have happened" (Buzzy Krongard);[69] "Without Block, the merger wouldn't have happened. The Block–Johns conflict was essential" (Morris Offit).[69] All agree that the increasing financial stress on the school and health system during the 1990s made the personality conflicts more difficult to resolve.[14]

Another frequently expressed point of view is that Block versus Johns was the catalyst, not the cause.[15,28,40,41,44,45,49,71,112,115,125,152] The former university president William Richardson believes that the medical enterprise at Hopkins would have eventually changed its structure even in the absence of the high-intensity controversy between the dean and the hospital president. "Even if they'd gotten on OK, the change might have been delayed. We couldn't help ourselves in the old way."[28] The unanswered question, however, is when.[41]

Whichever thesis one prefers, the two leading figures in the story, both extremely able men, had to leave for Johns Hopkins Medicine, in the form it now took, to function successfully. "The loss of Jim Block and Mike Johns was

a double loss for this institution," says Patrick Walsh. "However, it forced us to come to grips with an unworkable situation and find what turned out to be a wonderful solution. I am sorry that their careers at Hopkins were sacrificed in the process."[158]*

Was It Worth The Effort? Current Status

Reflecting on the importance of the Block–Johns imbroglio, Hamilton Moses says, "Organizations go through seizures of this sort. The outcome can be positive or negative. Those unpleasant years forced the hospital and university to make changes."[110] Speaking not as the neurologist he is but as the consultant he has become, Moses adds, "I see those periods of conflict as therapeutic. The changes were unfortunate and difficult for many people involved, but necessary and in the long run positive for the institution. The result has been clarifications of first principles and values."[110]

Since January 14, 1997, when Edward Miller became the first dean/CEO of Johns Hopkins Medicine, the new arrangement has become accepted as a superior structure for running the Johns Hopkins University School of Medicine and the Johns Hopkins Hospital and Health System. "We were crippled by not getting decisions made," remembers pediatrics director George Dover. "Now there's a clear line of authority. Ed listens, sets out priorities, and clearly articulates where he wants to go. He'll shift directions but not missions." Dover particularly appreciates Miller's "implementing rational fiscal policies."[22]

Completing the Howard County Hospital merger would probably have been impossible during the days of split governance under Block and Johns, as would an integrated planning process and the five- to ten-year capital spending plan for the health system and the school that Miller, Peterson, and their colleagues have been able to develop.

"Quiet" is the word many now apply to the administration in East Baltimore. This feature emanates from the dean/CEO and the hospital president

* Although they would no longer work in East Baltimore, both Johns and Block continue to contribute to medicine. Johns, who left before the governance changed at Hopkins, leads another respected academic medical center. Block is a consultant, an occupation that one of his strongest admirers among the Hopkins trustees thinks suits him particularly well. "Jim's smart as they come and perfect as a consultant. He can tell them what to do."[31] Among his engagements, Block has become a sought-after authority on palliative care. He helped "to focus the United Nations on completing its program for the worldwide eradication of polio," a particular suitable activity for the pediatrician in him.[9]

and extends into the boardrooms of the several corporations.* "They have transferred the energies from expansive toward inward-preservative, keeping the best people, getting the best people, keeping the quality," says Paul McHugh. "Before, the question was 'where were we going next?' Now it's 'how can we fight the threats?' "[20]

"We've knitted. It's all one culture today," says Morris Offit, referring to the growing significance of Johns Hopkins Medicine. "The marketplace no longer gives us the luxury of divided governance. We now make better focused and intelligent decisions."[59] Although the endowments remain separate,[59] Johns Hopkins Medicine now issues one financial review that combines the profit and loss statements and balance sheets of both the health system and the school of medicine. The information they supply has become essential to the management of the medical center. Hopkins can now reward directors and chiefs for combined accomplishments for Johns Hopkins Medicine rather than for just the hospital or medical school. The knowledge gained by a common bottom line helped the departments accept an additional 7 percent tax on gifts for capital replacement in the hospital.

Financially, the Johns Hopkins Hospital continues in the black, although only barely. The rate-setting Health Services Cost Review Commission has protected Hopkins and most other Maryland hospitals from losses but has prevented them from generating margins sufficient to replace capital. Although the cost commission increased the rate the Hopkins hospital can charge by 6.07 percent in January 2002,[160] Johns Hopkins Medicine still depends on its potent fund-raising abilities and aid from the state for capital improvements.

With all the inpatient beds at the hospital filled, Johns Hopkins Medicine can enjoy the luxury of rejecting contracts offered by poorly paying HMOs.† On a strictly financial basis, Hopkins should reject Medicaid, which pays doctors poorly. It does not do so because of its historical mission to care for

* Trustees of not-for-profit corporations dislike public discussion of internal problems as occurred in Baltimore when details of the latest conflicts between Block and Johns were regularly described in the local newspapers. The effects of such publicity can be formidable. At Hopkins, they contributed to the trustee-led changes in the fundamental governance of the enterprise. At Stanford University, the public discussion of the tribulations of the merger of Stanford's hospital with the medical center at the University of California, San Francisco (UCSF), helped to bring about the dissolution of the merger after only twenty-three months of operation.[159]

† For the fiscal years ending June 30, 2001, and June 30, 2002, the average daily census decreased slightly from 707 to 700 at the Johns Hopkins Hospital and from 238 to 237 at Bayview and increased from 130 to 135 at Howard County. The number of discharges grew from 41,614 to 42,466 at the Johns Hopkins Hospital and from 18,565 to 18,757 at Bayview and dropped from 12,782 to 12,705 at Howard County.[161]

local citizens without private resources.[116]* With its beds full, Hopkins is not strenuously looking for another large source of patients such as would become available if it purchased another hospital. Shifting bed assignments, however, offers some opportunity for admitting more patients with better-paying insurance or with illnesses which insurers tend to pay well for treatment. The effects of such redistribution, however, can be complex. For example, psychiatric admissions are poorly supported, but without them, research in the department, which is well supported by grants, would suffer.[116]

Despite its shortcomings, however, most believe that Johns Hopkins Medicine under the leadership of Edward Miller provides the institution with a more stable and constructive structure better equipped to deal with the current problems afflicting academic medical centers than the two-headed scheme that served the medical institutions for their first 100 years.[12,15,16,49,50,54,69,97,98,155] Miller continues to be praised, in part, because he is neither a James Block nor a Michael Johns. Some compare him, and favorably, with a former hospital president. "Like Heyssel, what you see is what you get." But, unlike Heyssel, "he's not fighting with anyone."[17]

"It's working better than anyone had hoped," says trustee Buzzy Krongard.[69] "It's the most stable structure I've seen here," says one executive who has worked at the medical center since 1990. "Now there's no longer a hero and a villain, a right way or a wrong way. There's much cohesiveness, not a medical school versus hospital place, but," he adds, "the Johns Hopkins Medicine concept might not work anywhere else."

The new arrangement has also met with praise beyond East Baltimore. Previously, insurers often found it difficult to achieve a consensus when dealing with two such strong-willed, dedicated people as Block and Johns and with no one to arbitrate their differences when Stobo was not around. With Miller now responsible to develop strategy aligning goals for both the medical school and the hospital, the institutions can speak with a single voice when negotiating with insurers. "They've done structurally and strategically the right thing," says William Jews, who leads the large Blue Cross/Blue Shield insurance plan in the mid-Atlantic region. "Now, when I contact Ed, he's responsive and can speak for the whole institution. Previously, I felt less confident that I could get a decision that I could take to the bank."[98]

* In the 1970s, Hopkins considered moving away from its deteriorating neighborhood in East Baltimore. "We decided to follow Johns Hopkins's instructions," remembers Furlong Baldwin, "to take care of the sick poor in our community. So we stayed where we'd always been."[27]

But everything is not perfect. Although top management has melded into one unit directing an enterprise spending $2.5 billion annually,[101] below that level, two administrations still function, and some redundancy and confusion persist. Reducing duplication, one of the goals of the reorganization,[68] has not progressed as far as many wish. Because of the extremely complex organizational structure, not all parts of the medical enterprise relate to each other in the most constructive manner. The decentralized administrative style of Hopkins, whatever its advantages, produces diffuse accountability and ambiguous lines of authority.[116]

Although the structure remains unorthodox and idiosyncratic, Hopkins veterans seem to enjoy the ambiguity.[116] Perhaps consequently, the process of decision making, always detail- and data-driven at Hopkins, remains protracted in many cases. Gradually, however, more authority flows from the office of the dean/CEO and somewhat less from the departments than under the former two-headed administrative structure. This change owes much to the consolidation of financial reporting from both the medical school and health system in Miller's office—the "all funds flow," as this method of accounting is called. With knowledge flows power, it is said, and, consequently, the financial data Miller now receives let him control better the earning and spending of resources throughout Johns Hopkins Medicine than could his predecessors, who only controlled the finances of one part of the enterprise.[101]

The ever troubling details of maintaining the clinical programs continue to dominate many discussions. At a recent retreat of the department directors and other leading executives, much of the time was occupied discussing hospital problems and such detailed topics as the coding of billing cards by those rendering professional services. Understandably, this preoccupation tried the patience of the scientists present and discouraged those whose primary occupations are research and education.[34] Despite the preoccupation of senior administrators with governance, however, most of the faculty have other things to keep them busy. "Most of us are quite removed from high level hospital politics," says Dr. Jonathan Orens, an associate professor in the pulmonary division. "The place is so big, and we're all extremely busy with individual clinical and academic pursuits."[162]

Many ask who won by the creation of Johns Hopkins Medicine—the hospital or the university? George Bunting, who along with Morris Offit have been called the two people who "put it all together," answers, "The university trustees think they won. The hospital trustees think everybody won."[16]

Offit's answer to the question is, "Johns Hopkins Medicine won, not one or the other."[30]

The next question on many minds is whether this currently comfortable arrangement will work as well when different people fill the top jobs. "If you have the right people, it'll work, but if it's the wrong people, it won't work," says Bunting.[16] Andre Brewster agrees. "Success depends on people, more than on organization or structure."[74]

What Makes Hopkins Hopkins?

Hopkins survived the turmoil associated with the Block–Johns conflict and the revision in its government structure without significant deterioration in its standing as one of the nation's leading academic medical centers.[92] The faculty in the medical school continued to conduct research with a quality that allows them to generate more funds from the National Institutes of Health than all other similar institutions with the exception of Harvard. At the beginning of 2002, seventeen members of the faculty were members of the National Academy of Sciences and thirty-eight of the Institute of Medicine.* Even after accepting the inherent limitations of such a ranking, one cannot deny the consensus provided by the magazine *U.S. News & World Report,* which consistently lists the Johns Hopkins Hospital as number 1.

To what can one attribute these accomplishments? Many currently at Hopkins and others who have trained there think that it all started with the unique features of the founding.[15,163] Johns Hopkins created a medical school and a hospital linked together for the care of patients and instruction of students, all based on the application of the latest scientific discoveries, an activity in which the Hopkins faculty would lead the way. As the Flexner report made clear almost a century ago, it was the leaders of the new institutions in East Baltimore that established, in only twenty years, an integrated method of education, patient care, and research that we now accept as commonplace in America's leading medical schools and teaching hospitals.

Hopkins devotees believe that the first professors, Halsted in surgery, Kelly in gynecology, Osler in medicine, Welch in pathology, and their colleagues in the basic sciences set a tone for the institution that has endured.[43,84,163] On the walls of many offices of both doctors and executives hang pictures of early buildings and renowned professors. The executives of the hospital as well as

* The academy recognizes outstanding accomplishments in all disciplines of scientific research. Most of the institute's members are academic physicians who are leaders in their fields.

the doctors in the medical school are also inculcated with the culture. A copy of a letter from Johns Hopkins to his trustees setting out what he wanted built in East Baltimore hangs on the walls of many of their offices.[155] "Many of us feel we are the inheritors of a great tradition in American medicine," says cardiologist Stephen Achuff, a history buff who helped create a small museum in the room where Osler wrote his famous text on medicine while waiting for the medical school to open.[43]

Hopkins nurtures its reputation by skillfully marketing the unique features of its accomplishments, history, and culture. Clinical department director Charlie Cummings may be less immersed in the Hopkins mystique than some because, when he arrived in 1991 to direct his department, he had not previously trained or worked there. Nevertheless, he has seen that "it's hard to escape the Hopkins aura, molded and marketed so that the culture and heritage form unique attributes of the place." However, he adds, "its image of itself is one of its heels. People love to take shots at us."[12]

Awareness of history and tradition may be fine, but the innovations of Osler and his colleagues did not necessarily have to continue. They did, as Steven Muller has observed about the early faculty and their successors, "because they hired people as bright as they are. There's an uncompromising and deeply inbred commitment to quality. If you can't hack it, you don't stay."[84] John Lombardi, provost of the university during the later part of Muller's presidency, describes the Hopkins culture as consisting of "the ruthless pursuit of excellence with a focus on performance and weeding out the nonperformers."[89]

The tradition of recruiting and employing only the most able medical students, trainees, and faculty and then actively retaining the best[14] assures that Hopkins continuously renews itself,[15] proving that good people beget good people.[13] The "ferociously bright students and trainees stimulate everyone," says vice-dean David Nichols, "and provide the source for ideas and future faculty."[102] When asked what keeps Hopkins going, Michael Johns replies from his office at Emory, "It's always looking for the best people."[24] William Agnew, when recruited to lead one of Hopkins's basic science departments, remembers, "I came here because of competence. Everyone knew what they were doing."[34] Patrick Walsh adds, "It's the chance of discovery that excites them, brings them here, and keeps them from leaving."[18] According to data in the dean's office, 95 percent of candidates offered jobs in Hopkins basic science departments accept.[152] "If you can't build something from that material," says neuroscientist Guy McKhann, "something's wrong."[40]

When the question "What are our core values?" was discussed at a retreat

of department directors and the administration, two answers predominated. Number 1 was excellence. Next was collegiality, "but close, just behind," remembers Murray Sachs, director of the department of biomedical engineering.[50] "In my department, we value collegiality as essential and find that it's infectious. If we hear that a candidate for a position lacks it, he's out."[50] Daniel Nathans, who was interim university president during some of the most troubled days in the battle between the hospital and medical school, exemplified this word. "He was so honest and gentle," remembers Jeremy Berg, one of the basic science department directors. "It trickled down to a lot of people. If you behave badly, you stand out like a sore thumb. Most people are indoctrinated in this approach," Berg continues, "so there's little guerilla warfare about things. When recruiting directors, we pick people who will fit it, who are collegial and not hyperaggressive."[42] As former university president William Richardson discovered when he came to Hopkins, "The collaborative spirit is in the blood, in the culture and deeply ingrained."[28] "People have a lot to gain by working together," explains Berg. "You're too busy to do it all yourself. It's hard enough trying to compete with nature about how things work."[42]

Accordingly, many at Hopkins believe that collegiality and collaboration account for much of its success in research and in the development of its faculty, in spite of the competition for promotion, grants, and scientific recognition inherent in such a place.[43] "People here are intensely competitive in themselves, not against others," in Sachs's experience.[50] As pediatrician George Dover has observed, "I've never heard of another place where careers can be built on collegiality and collaboration."[22] Dover, who discovered a treatment for sickle cell anemia, had no laboratory of his own for the first twenty-one years of his career[22] and, like many other young academics in clinical departments,[108] trained how to be an investigator in the facilities of a basic scientist.[22] "The clinical departments never begrudge us the clinical income that flows to us," says Thomas Kelly, director of molecular biology and genetics. "Their fellows work with us and then go back to run labs in the clinical departments. There's so much flow back and forth."[14] Hopkins aficionados like to compare the collegiality of their school with the customs in "Boston" (read Harvard). There, many have seen, heard, or assume, "everyone has his own fiefdom," according to one senior faculty member at Hopkins, and "is constantly cutting each other up," according to another. "It's the most extraordinary thing I've ever seen," says Agnew. "Not like this at any of the other places I've worked."[34]

What is the source of this characteristic in which the faculty take such

pride? "Tradition counts as does the esprit de corps among the faculty," Guy McKhann believes. "This produces a very enriched academic environment—one of our big strengths."[40] Another more sociological explanation appeals to many. "It comes from the drive of the North," as one senior executive observed, "and the gentility of the South meeting in Baltimore." And lest one think that everybody buys this concept, Michael Johns, now the senior spokesman for another fine medical center, feels that "although I valued collegiality and promoted it throughout my time at Hopkins, I didn't find it significantly better or worse there when compared with my experiences elsewhere."[23] Perhaps the former dean was reflecting on his last years at Hopkins. "The Block versus Johns days," observed one senior member of the faculty, "was the one aberration in collegiality that I can remember," and then adds, "but that's the way it is at Harvard all the time!"*

Many faculty feel that the decentralized nature of the Hopkins governance, which is characteristic of the medical school as well as the hospital, contributes to the spirit of innovation and independence.[14,15,40,71,108] "This is a place where people who are bright and excited about what they are doing have a chance to do it," says Marty Abeloff. "The decentralization has allowed us to be creative and develop services that would otherwise not have developed."[15] Delegation of much of the authority to the department directors has encouraged the strongest and most able to build outstanding units.[14,40,76]

Hopkins lives on the entrepreneurial enthusiasm of its faculty since the medical school has few funds to support departments and investigators and depends so much on "soft money," the grants won by the faculty.[61]† This is vitally important since few members of the faculty develop enough money to support their colleagues in addition to themselves.[49] "Hopkins gives you a hunting license," is the way several faculty members describe the value of the Hopkins connection. "They don't give you much but they don't get in your way," says McKhann.[40]‡

* Hopkins faculty members acknowledge that, in the words of ENT director Charles Cummings who trained there, "Harvard has more great people than us, but," then adds, "there's less cohesion."[12]

† Although medical academics usually use the phrase "soft money" to refer to grants, clinical income is similarly "soft" in that its presence is not as assured as are student fees or income from endowments.[61]

‡ Once past their seeding periods, basic scientists at Hopkins must support 60 to 70 percent of their salaries from grants.[61] In most other schools, this requirement is less. The same economy applies in the clinical departments. Among the 120 faculty members in George Dover's department of pediatrics, clinical revenue supports only thirteen and hospital and school funds twenty. The rest live on grants.[22]

The size of Hopkins, however, can be intimidating as well as constructive. Recently appointed junior faculty members may find it difficult to get their programs started. If all goes well, however, "success builds on success because of the size and depth of the institution," says pulmonary division specialist Jonathan Orens. "There are always numerous people available with overlapping research interests, thus allowing great opportunities for collaboration. One rarely needs to look beyond the walls here to find specific expertise."[162] Orens, who was recruited to Hopkins from the University of Maryland across town, had heard that Hopkins was cold and nasty because everyone is so high-strung. "Completely untrue," he found. The competition is internalized. "Because most faculty are so successful, everyone's willing to support and help. However, at times, one can feel lost in the bigness of the place."[162]

Despite Hopkins's reputation in research, the basic science departments, where much of the fundamental medical science originates, are relatively small. Their average size is about fifteen members, and the research groups are even smaller, unlike some of the groups in "Boston" and "Cambridge." Nevertheless, believes Agnew, "the basic science chairs have a disproportionate influence considering our numbers. This reflects the historical importance of scientists since the founding of the School of Medicine."[34] The directors think that the absence of departmental boundaries among these groups provides one reason why their colleagues are so productive. "There's little sense of turf," says Berg,[42] and, Agnew warns, "if we become less collegial and more turfy, we'll be in even bigger trouble."[34]

Many have asked why this extraordinary place developed in Baltimore, Maryland. Obviously, the first answer is that is where the founder lived and sited his university and hospital, but it is not East Baltimore[42] or the facilities that account for its continuing success. "I'd rather live in San Francisco," explains Gert Brieger, director of the department of the history of science, medicine, and technology at Hopkins from 1984 to 2002, when the University of California, San Francisco tried to keep him there, "but I'd rather work at Hopkins."[76] It is not the facilities, which, although adequate, have many shortcomings.[97] "We've got the dome, but it's not a palace," says one senior clinician,[118] and few get rich on the salaries Hopkins pays its full-time faculty.[18,100]

It is Hopkins's reputation in clinical medicine, however, that creates much of the esteem in which the public holds the institution.[83] John Stobo, the former director of the department of medicine and later the first president of Johns Hopkins HealthCare, stresses how highly the Hopkins culture empha-

sizes patient care. He recalls how, at another famous medical center where he worked, if the chairman phoned him while seeing a patient, he would interrupt what he was doing and talk to his boss at once. "At Hopkins, when I was chairman, I called one of the GI guys who was in the clinic. He sent a message saying he'd call me back when he was finished with his patient. You don't see that 'patient comes first' attitude at every place."[41]

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CHAPTER EIGHT

Conclusions

What accounted most for the change in governance at the medical centers of the University of Pennsylvania and Johns Hopkins University, problems with the governance structure, current events, or internal conflicts produced by leading personalities?

Structure versus Personalities versus Money

At Penn, both the financial reverses of the health system and the conflict between the head of the medical center and the president contributed to the round trip the governance structure took. The loss of $300 million over a three-year period and the accumulation of $800 million in debt alarmed the university trustees who, fearing that continued losses would reduce the value of the endowment on which all the schools of the university depended, sought to shield the rest of the university from the financial instability of its health system. Their task, which required understanding the operations of an enterprise of immense size and complexity about which few of them had professional familiarity, conflicted with the faculty's wish to retain control over the

health system for the benefit of the school of medicine. As the trustees and executives of the university debated what action to take, the faculty, shuddering at the thought of HUP's being sold to another corporation, made clear that loss of their principal teaching hospital would seriously injure the academic mission of the school.

The more the leaders and the special committees appointed to study the problem looked, the more they came to see the problems as well as the advantages of separation. Lawyers asked for their opinion advised that, without completely taking apart the 130-year relationship with its principal teaching hospital and with the more recently acquired community hospitals, primary care practices, and other entities, the university could continue to be held accountable for the finances of the health system.

This controversy helped to explain why no conclusive action was taken from the time of William Kelley's discharge in February 2000 until the hiring of his successor in July 2001. Then, when the candidate the president most wanted to succeed Kelley insisted that he also control the health system, the debate ended. Ironically to some, gratifyingly to Kelley, the organization by 2003 appeared structurally similar to the one Kelley had been hired to lead in 1989. In a slight change, a single, rather than several, groups of trustees would supervise, on behalf of the university board, the activities of what would now be called Penn Medicine,* consisting of the school of medicine, the faculty's practice plan, and the health system.

Meanwhile, using methods Kelley had instituted during his final year as CEO/dean, the new health system director and his colleagues reversed the operating losses. A large debt remained, however, which cost significant amounts of money to service. Arthur Rubenstein, the new dean, might well reflect on how he would have spent the millions of dollars no longer available that had been allocated to purchase and operate primary care practices and hospitals during the enthusiasm to construct an integrated delivery system, the solution, many earlier thought, to the challenges produced by managed care.

Of what importance to the governance change was the conflict between William Kelley and university president Judith Rodin? Their dispute initially arose from the presence on the campus of two strong, highly able, and intelligent leaders neither of whom had appointed the other. Soon after she became president of the university in 1994, Rodin, a very different personality from her

* Thus Penn had adopted the same formula for naming the overriding entity as had Hopkins.

predecessors, indicated that she planned to apply greater control over the university's vast enterprise centered south of Spruce Street. Kelley wanted to retain the authority he had exercised with minor limitations under two previous presidents. Whereas Rodin believed she was fulfilling *her* responsibilities as university president, Kelley saw her as interfering with *his* responsibilities as health system CEO.

When the losses began appearing about three years later, Rodin had the opportunity to rein in her powerful colleague as his triumphs of the first half of the 1990s converted into deficits for which the university president could be held ultimately responsible. In February 2000, backed by a new leader of the university's board of trustees, Rodin discharged her medical center leader, convinced that he had inadequately responded to the new economics—an accusation Kelley adamantly denies. Notwithstanding the depth of their interpersonal conflict, Rodin could not have fired Kelley without the losses, and without the losses, change in the governance of the medical center would not have become an issue.

Since he was fired, Kelley's irritation at Rodin has grown rather than lessened. While acknowledging that the losses developed on his watch, Kelley claims that he had developed and then executed the program that would repair the finances of the health system, that he could constrain as well as build, and that the evidence for this was clear when he was, as he sees it, inappropriately relieved.

Clearly, the conflict between Kelley and Rodin played a major role in the events of the late 1990s at Penn. If their relationship had been more congenial, Kelley might still be leading the medical center that he so greatly improved, providing, of course, that he could have continued to fix the health system's precarious finances.

Ninety-five miles to the southwest, few thought that the century-old separate governance of the Johns Hopkins school of medicine and hospital would require change when Michael Johns and James Block began their terms as dean and president. Although many had talked and written about the wisdom of combining the two entities that Johns Hopkins had so specifically created as separate corporations, the power of history and tradition and the absence of difficulties sufficient in magnitude to force a resolution had prevented any substantive changes in the governance of the East Baltimore institutions.

Whereas financial problems constituted a major force driving the University of Pennsylvania to consider restructuring its medical center, other fac-

tors brought about Hopkins's governmental changes. In "liberal, regulation-friendly, uncompensated-care-conscious Maryland,"[1*] the Health Services Cost Review Commission helped sustain the financial base of well-run hospitals as it limited the surpluses that Maryland hospitals could generate. The active participation of the conservative hospital board prevented James Block from generating the debt that Kelley accumulated during the first half of the 1990s to be followed by the operating losses that appeared after the gold rush had passed. Furthermore, the two academic medical centers in Baltimore—rather than the six and then five in Philadelphia—did not face competitive pressure from for-profit hospitals as they did in Philadelphia. The opportunity for profits, tightly controlled by the cost commission, was too slim to encourage invasion by such companies.[2,3]

So, unlike in West Philadelphia, money was not the prime factor that brought about the changes in governance and personnel in East Baltimore. Almost everyone at Hopkins interviewed for this study agrees that the conflict between the dean of the school of medicine and the president of the hospital prompted the conversion. James Block recognizes this. "The Hopkins threats were internal. Shakespeare should have written about it because of the human issues involved."[4]

Would Johns Hopkins Medicine have been created without the conflict? My opinion is that it would not. Granted, the issues facing the leaders of academic medical centers are formidable. As Hopkins trustee Shale Stiller has observed, "Financing academic medical centers is the most complicated financial thing I've ever seen. It's like an algebraic formula with eight unknowns that keep changing."[5] Nevertheless, executives working in harmony with each other could have resolved contentious issues for the good of the entire enterprise. Robert Heyssel and Richard Ross, both strong personalities, did it in the 1980s. Edward Miller and Ronald Peterson are doing it in the twenty-first century and would probably have been able to do it under the old structure in which Peterson would have reported to his board of trustees rather than to Miller.

The legacy of the conflict lingers. Faculty members and administrators took sides during the bad days, and many continue to assign responsibility to Block, to Johns, or to both of them. All agree, however, that the new system works well, although opinions differ over how much of the calm is due to the new

* As Harold Cohen, the Health Services Cost Review Commission's first executive director, describes the health care financing scene in Maryland.[1]

leaders or the new structure. One cannot help wonder whether if James Block had left Hopkins first to be succeeded by Ronald Peterson and Michael Johns had stayed rather than the other way around, might peace have returned to the campus without changing the governance?

As far as Penn and Hopkins are concerned, Mark Rogers observed, "for academic medicine to make big changes, there has to be a level of unhappiness to make a rational decision," and then adds, from the point of view of a former professor who left the university for business, "since irrational changes are so likely in academics. Organizational structures that wouldn't work in business can work in academics."[6]

Role of the Boards

The boards of trustees responsible at Hopkins for the hospital and health system exercised greater supervision over their charges than did the trustee board over the health system at Penn. We have seen how the Hopkins trustees rejected several of James Block's more expensive initiatives. Although Block had less money at his disposal than did Kelley, Hopkins could have borrowed to develop an integrated delivery system. But this didn't happen. Was Block simply less persuasive than Kelley? This seems unlikely. Although Kelley had the stronger academic accomplishments and carried the title of dean as well as CEO, Block, everyone at Hopkins acknowledges, could persuade with great skill.

An important difference seems to lie within the boards themselves. The members of the Hopkins hospital board, in existence since the founding, were accustomed to intervening in hospital administration and planning. Penn's trustee board of the health system, created only in 1993 and populated with many of Kelley's admirers, had had little time to become intimately involved in the affairs of the health system before the financial losses developed. Until the university president and her staff began to question what Kelley was doing, few at Penn probed Kelley's actions with the intensity of some of the Hopkins hospital trustees. By the later 1990s, their extraordinarily effective builder was now called upon to deal with a financial picture different from any he had ever faced in his distinguished career. He needed help, but his board members, at least at the beginning of the trouble when its severity might have been reduced, did not provide it.

Several questions arise. Presuming the business leaders on the board were informed about the changing environment, a concession not all at Penn would

make, why did they fail to recognize that the early losses were harbingers of greater deficits and not temporary glitches? Would a chief operating officer, a position Kelley had not filled since Wilbur Pittinger departed in 1995, have helped Kelley to react sooner? Kelley responds that the finances deteriorated very rapidly—which is certainly true and characteristic of current medical economics—and that he did consult closely with several members of his board, many of whom were distinguished leaders in business and law.

Did the absence of an experienced executive from another distinguished academic medical center on the executive committee of the health system board account for any of Kelley's troubles? Suppose someone like Dr. Samuel Thier, the able CEO of the merger of the famous Massachusetts General and Brigham and Women's hospitals in Boston and a longtime friend of Kelley, had been a member. He might have seen more clearly than some of the other trustees what was happening and, speaking the same language as Kelley, have guided his friend through the shoals he was facing. Before the losses became clear to everyone, the principal people to criticize Kelley were the president and her staff, and we have seen how the relationship between Kelley and Judith Rodin became increasingly confrontational, reducing its effectiveness.

This analysis suggests that some hospital trustees, particularly those on executive committees, should be appointed specifically for their abilities and experience in academic health care, hospital management and financing, and relevant subjects. They must be committed to independently judge, not just approve, the plans and actions of the executives. Of course, they will fail in this responsibility if the staff provides them with biased or incomplete data or the executives routinely degrade their questions or reject their suggestions.

Regrettably, it is the impression of authorities in the field that useful and competent hospital boards are the exception rather than the rule in the governance of teaching hospitals.[7] "Boards never know enough to run the place," says Dr. Thomas Detre, formerly in charge of both the health schools and the hospitals at the University of Pittsburgh. "The complexity gets beyond them. They're never sufficiently on their toes to control their CEOs."[8]

Integrated Delivery Systems

The pros and cons of building integrated delivery systems at university teaching hospitals is beyond the scope of this discussion although it would appear that enthusiasm for their creation, so much the vogue in the early

1990s, has abated.[9] Suffice it to say, in the centers studied here, William Kelley built a comprehensive system when he had the money to do so. Hopkins did not because it did not have the cash and did not want to borrow to buy hospitals and primary care practices.

Few at Penn's medical school objected to Kelley's plans for the health system, in part because, until the losses appeared, Kelley was investing large sums in what faculty members love—building and renovating laboratories, recruiting first-rate investigators, and supporting research. Furthermore, Kelley was in charge of everything. Few professors and administrators would challenge such a strong leader with a record, so far at least, of extraordinary success.

At Hopkins, faculty leaders had little hesitation confronting Block when they saw him spending money to expand the health system rather than supporting the academic needs of the school. They felt free to challenge the hospital president since, unlike Bill Kelley at Penn, Jim Block was not their boss. Their colleague Mike Johns was.

Hopkins loyalists also credit an inherent conservatism in the Hopkins medical culture, "part of our institutional personality,"[10] for preventing entry into the hospital and physician buying sweepstakes. It took a new governance structure to provide the calm that would allow Hopkins to purchase Howard County General Hospital without the faculty's objecting.

One difference between how Penn and Hopkins handled the professional staffs at their newly purchased community hospitals reflects both the differences in management style between Kelley and Edward Miller and the lessons that a few years of experience taught the Hopkins executives. When Penn bought Presbyterian Hospital in 1995, Kelley and his chairmen proceeded in the time-honored process of making full-time the self-employed physicians there or replacing them with full-time faculty. Employing the doctors and owning their practices was the accepted method of running clinical programs in owned and tightly affiliated teaching hospitals and had become the modus operandi at leading medical schools since the 1960s. Substantial turmoil and financial losses followed.

Three years later, when Hopkins bought Howard County General Hospital, the leaders of the one-year-old Johns Hopkins Medicine, concluding that the local doctors knew better how to conduct their practices and their professional lives than did the academics in East Baltimore, avoided any effort to force them into full-time arrangements. Capital that would need to be spent for this purpose was saved, and the anxieties of the local doctors were relieved. Signifi-

cantly, Hopkins bought a hospital that was not yet losing money although its executives feared that, unless it joined a medical center like Hopkins, this might happen. In buying Presbyterian and Pennsylvania hospitals, Penn acquired two hospitals that were already losing money. "My father told me," remembers Edward Schwartz, the HUP director before Kelley and Pittinger arrived at Penn, " 'Never accept a gift which eats.' Don't buy liabilities, buy assets. If the bottom line's black, many things are tolerable; if red, nothing's tolerable."[11]

Similar reasons, however, prompted the purchase of the community hospitals in both Philadelphia and Baltimore. Both Kelley and Miller worried that if competing health care systems acquired them, the academic centers would lose the patients these hospitals had sent, and might refer in the future, to them.

Thus, the financial and organizational turmoil aroused by attempts to assure the survival of teaching hospitals, so characteristic of the 1990s,[12] contributed to the personal angst that developed between the leaders at Penn and Hopkins. What finally happened in Philadelphia and Baltimore differed in keeping with the original governance of both institutions. While the trustees at Penn tried to split their health system from the university, the Hopkins trustees decided to put the parts together.[13]

Is the Job Too Big for One Person?

Although at Penn and Hopkins, one man directly leads both the medical school and health system, this system of governance is relatively uncommon among America's academic medical centers. Why is this so? One reason may be that the jobs exceed the capabilities of one person. They require different skills and experience, and few academic physicians have them all. Deans are expected to have concentrated their previous efforts in academic work, by conducting research and, if holding the M.D. degree, to have demonstrated clinical skills. Most will have directed academic departments or large divisions, and in these positions, have accumulated some of those administrative skills peculiar to medical academics.

The CEO of the university hospital and health system, however, must direct a large, sometimes billion-dollar enterprise providing clinical services based on the employment of thousands of employees. He or she—a few women are teaching hospital CEOs—will be ultimately responsible for coordinating a complicated, scientifically based service provider, with large financial under-

takings often including sizeable debt, expensive real estate, and large endowments. While managing these activities, the executive must maintain successful relationships at several levels of the university's administration or with governments and with those pesky professors. He must also be able to satisfy his boss, whether senior academic officer or board of trustees, for his job depends on the skill with which he does this. These are not the skills that even the most distinguished investigator or clinician tends to accumulate, even if he takes an MBA or cram courses on accounting and management from distinguished business schools.

Students of business and executives who are not physicians wonder about the suitability of professors leading such enterprises.

— "Running a health system is looking like any other business," says health care authority Mark Pauly from Penn's Wharton School. "If the financial indicators turn adverse, the CEO gets the hook."[9]
— "If he has the MBA point of view, he probably won't have the academic research credentials required to lead the faculty successfully."
— "One of the biggest risks in health care is that few of these immense organizations are being run by people who are adequately experienced," says Gavin Kerr, one of Kelley's former executives. "Think of the skills needed, an academic dean plus the business skills of the leader of a Fortune 500 company plus the political skills of a presidential candidate. And the organizations are so complex—politics, doctors, researchers, helicopter pilots, etc."[14]
— Emphasizing the ambiguity of these positions, Hopkins trustee, business leader, and New York City mayor Mike Bloomberg says, "They always look for great academics though the top job is administrative."[15]

Complicating the management of teaching hospitals, the profession of health care administration, particularly in the not-for-profit sphere,[14] does not attract the best and the brightest in the experience of Robert Burns, professor in the department of health care systems at the Wharton School, and others interviewed for this book.[16] "The pay is low, the career ladder huge and long," says Burns. "Besides, why get beat up on by doctors?"[16] Consequently, if one takes a particularly jaundiced view of teaching hospitals led by academic physicians, one may find inexperienced chief executives assisted by associates with limited abilities and ambitions.

Consequently, finding an academic doctor fully suited to run a large health system is very difficult. The trustees at Hopkins acknowledged that few of the candidates they considered seemed right for the job to which Edward Miller was appointed. At Penn, Arthur Rubenstein, who succeeded William Kelley, was the only first choice, and, according to several close to the search, there were no second choices among the finalists for the job.

Some manage to do it, however. William Kelley is an excellent example, an investigator, internationally recognized for his research, with an intuitive sense of management strengthened by his experiences building the research and clinical services of a large department at a distinguished medical school. His success increasing the academic prowess of Penn could have been predicted by his record at Michigan. Expanding the health system must have seemed to demand similar skills. Now, however, he was not recruiting investigators, teachers, and clinicians, but people skilled in different fields where he had not personally worked. So long as the money flowed, he could fulfill his dreams, prompted by consultants whose advice seemed so reasonable at the time. When the tap ran dry and consolidation was called for, the system he had developed failed to staunch the losses early enough, and his job was forfeit.*

Some of Kelley's colleagues think part of the problem was the size of his job. "The job's too big," says Arthur Caplan, the well-known authority in medical ethics at Penn. "One person can't do the dean thing with all the health system issues."[17] Gideon Dreyfuss, a senior investigator at Penn, agrees. "Both jobs need full-time attention. One person cannot know and encourage the faculty, answer such questions as where is science going, and also be the CEO."[18] "Bill Kelley's the best you could find, and even he couldn't do it," concludes one of his senior clinical chiefs.[19]

Many who lead or have led academic medical centers think it unwise for them to also direct their schools of medicine.

— Michael Johns, who left Hopkins to assume a position with authority over both the Emory school of medicine and teaching hospital, "wouldn't take the dean's job also. You need a full-time dean and full-

* Kelley's everyday title of "CEO/dean" supported the contention of those who accused him of becoming preoccupied with the health system over the school. Miller strongly favored being called "dean/CEO," to indicate that at Hopkins, the academic enterprise came first. Despite his title, however, some at Hopkins think the hospital and health system still take too much of Miller's time.

time subdeans." Chancellors, whom Johns believes should be physicians, "should be comprehensive to foster integration."[20]

— Jack Stobo, who, like Johns, left Hopkins for a similar job, feels the dean/CEO structure is "problematic. In my case [president of the University of Texas Medical Branch at Galveston], there's so much else to do—development, community, legislature, Washington, developing a vision with the university, and addressing the needs of 14,000 employees, 1000 of whom are faculty—that would be impossible to do if one held both jobs."[21]

— Ralph Snyderman at Duke feels similarly. Although he also served as dean when he was first appointed chancellor for health affairs, Snyderman appointed a dean several years ago. "I formerly felt I could do it," he says. But now, thanks to the increasingly complicated developments in the administration and financing of health care, Snyderman feels that "you can't maintain a top status medical center doing both jobs."[22]

— Philip Pizzo, dean at Stanford, favors not having operational responsibility for Stanford's teaching hospitals as well. Upon being appointed in 2001, he found that "the faculty were looking for someone to represent them who would not be distracted by providing direct oversight over hospital management."[23]

Although many find that functioning as dean and head of the health system is more than one person can handle successfully,[8,24,25] others disagree, not surprisingly, those currently in such positions.

— Edward Miller finds his job definitely doable. "One needs to be smart about priorities," he says.[26]

— Gerald Levey, who leads the school of medicine as well as its three major teaching hospitals at the University of California, Los Angeles (UCLA), says, "It brings a tremendous workload, but it's not too much. The job places a high premium on having very good people."[27] Levey acknowledges that the health system takes most of his time, "maybe 65 percent."[27] Clearly, those in these positions cannot devote as much time, energy, and leadership to the school of medicine as a full-time dean can.

— Edward Holmes, who likes being both dean and vice-chancellor for health sciences at the University of California, San Diego, freely admits

that "both jobs are tough for one person to do. The dean job is the fun job."[28] Holmes believes that the senior officer, while overseeing the whole operation, should concentrate on the dean's job.[28]

Some find the interposition of a chancellor between the dean and more senior university officials a problem.

— Jerry Levey at UCLA believes "having a separate provost at our and other academic medical centers adds further potential for personality conflicts by interjecting a third individual in the hospital-medical school governing mix."[29]
— Ed Miller agrees. "A chancellor brings ambiguities. Three leaders doesn't make governance better, but when there's two, there's give and take on both sides."[26]
— Dr. Kenneth Shine, the former president of the Institute of Medicine and, in a previous life, dean at UCLA, also favors single leadership. "Troikas don't work too well," he believes, and adds, "the modern academic medical center must have a single focus of leadership."[30] Shine does not favor the person in charge of the medical school and hospital also leading the other health-related schools on the campus. "How can one overcome the conflict of interest since [M.D.s in such positions] have loyalty to the medical school and the hospital."[30]

Complications of Being Part of a University

Since Flexner emphasized almost a century ago that medical schools should be based in universities, this structure has become the standard in the United States, and few contest that this is where these institutions that teach and conduct research belong. Nevertheless, both Richard Ross at Hopkins and William Kelley at Penn toyed with changing the ties binding their schools to their universities, in each case because of actions taken by their bosses, the university presidents. Ross suggested creating a new entity for the East Baltimore medical enterprise that would relieve his successors from reporting primarily to the president. Kelly wanted to report directly to the university trustees and thereby bypass the president. Neither scheme was adopted.

Whether hospitals and health systems belong within universities is not only less certain but, many claim, ill-advised.

— "I don't think universities are very good at running health systems," says Dr. David Blumenthal, an authority on such matters who works at Harvard and the Massachusetts General Hospital. "They're too hard to run. It really requires a different mentality."[9]
— Combining hospital and medical school functions "takes the level of complexity to a new level," says Dr. Eliot Sussman, a former Penn faculty member and administrator, remembering what a trustee at the University of Chicago once told him.[31]
— Russell Palmer, the former dean of the Wharton School who led Penn's medical board during the recovery from its losses and favors a separate corporate structure for the health system, has concluded, "you can't run a big commercial health care system within a university."[32]

Is There a Correlation between Governance and Academic Success?

Does governance of academic medical centers correlate with the amount of research support received from the National Institutes of Health, a criterion to which schools like those at the University of Pennsylvania and Johns Hopkins University look in measuring their standing?* Among the thirty schools with the most NIH money:

— Private entities own 57 percent and the states own 43 percent of these schools in a nation in which 60 percent of all medical schools are government-owned and 40 percent privately owned.
— The governance of the principal teaching hospitals usually correlates with the governance of the medical school with which they are affiliated. Thus, governments owned none of the principal teaching hospitals of the research-intensive private medical schools in this group, and in only one case is the teaching hospital of a state school owned other than by a government or governmental agency.
— The arrangement at Penn and Hopkins, in which the chief executive of the principal teaching hospital reports to the dean, applies to only seven of the thirty.

* To avoid further inflating the egos of the faculty and alumni of those schools that lead the NIH race and discouraging those whose schools compete less successfully, I am not displaying the tables I created to study this subject.

— All but six of the thirty schools with the most NIH research money were founded before World War II. Thus, most of the research-intensive schools have been in business for many years with a long history of working closely with their affiliated teaching hospitals whether or not the school and hospital are commonly owned.[33]

Research success does not seem to depend upon:

— Common governance of medical school and hospital. The principal teaching hospitals of twelve* of the thirty schools with the most NIH support are separately governed from the medical school with which they are affiliated.
— The chief executive of the hospital reporting to the dean. In only seven of the thirty, two private and seven state-owned, is this the case.
— Administrative dominance of the university in those academic medical centers with separate governance. Of these, only at Hopkins is the university dominant. The most dramatic example of successful separate governance in which the university does not rule is Harvard. The faculty in its medical school and principal teaching hospitals generate more than twice as much NIH support than does the distinguished faculty of the number 2 in the race, Johns Hopkins. Each of Harvard's famous teaching hospitals is independently governed. However, the leaders of these schools and their hospitals usually work closely together, so that the bonds between them remain functionally tight despite separate governance. We have seen, however, that this harmony may not apply at all times in every school!

Of the thirty schools with the least NIH support, governments own 73 percent, a larger fraction than among those with the most research support (40 percent) and larger than among all American medical schools (60 percent). The teaching hospitals, in this group, are often community hospitals or other privately owned hospitals unrelated governmentally to the medical schools. In only three schools does the CEO report to the dean. Since, with a few notable exceptions, relatively little NIH-supported research is conducted in community hospitals,[30] most schools that are primarily affiliated with community hospitals generate small amounts of support from this agency. The principal

*I am including Johns Hopkins among those whose schools and hospitals have unified governance although, as we have seen, the union is functional, not corporate.

mission of many of these schools is training practicing physicians and not generating research.

Structural Change at Academic Medical Centers

Based on the two cases reported here, the structures changed less because of inherent faults in governance than because of severe financial losses in the case of Penn and conflicts between senior executives at both Penn and Hopkins. That the structure at Penn returned to its original form provides further evidence that people and money more than structure dominated what happened in Philadelphia. Although money was less an issue at Hopkins, if it were not for the conflict between the two leading executives, I believe that the medical school and hospital would still be separately governed.

Distinguished leaders of leading American schools of medicine favor different structures, often the structure under which they work and with which they are familiar. At times, however, candidates for senior positions insist that the structures be changed before they accept. This happened at the University of California, Los Angeles, when a nominee who was offered the deanship insisted he also have responsibility for the teaching hospitals. This was arranged. Although the candidate decided to stay where he was, the new structure was in place for Gerald Levey when he was offered the position.[30]

Although students of governance[34] as well as chief executives, deans, and candidates for such positions may favor one form or another,[35-39] this study suggests that whether an academic medical center successfully meets its inherent responsibilities to teach, advance medical knowledge, and provide exemplary clinical care depends more on the character and ability of its faculty and its leaders than on the structure under which they are governed. As one dean has said, "There isn't an ideal governance model. It's locally defined and impacted by whoever fills the roles."[23]

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Architect's drawing of the original Hospital of the University of Pennsylvania, facing Spruce Street from the south. The wards extended from the back. *From the author's collection.*

Dr. Alfred Gelhorn, dean of the University of Pennsylvania medical school from 1967 to 1973 and, for part of that time, also in charge of Penn's hospitals. His supervision of both school and hospitals would trouble the university's leadership, a problem William Kelley would also later face. *From the Collections of the University of Pennsylvania Archives.*

Sheldon Hackney, Penn's president from 1981 to 1993. His concern that "no one was in charge of it all" led to the creation of the entity that William Kelley would dominate in the 1990s. *From the Collections of the University of Pennsylvania Archives.*

Dr. William Kelley in 1992 when HUP was a "money machine," and the future seemed bright. Penn's medical czar and a virtuoso among the leaders of academic medical centers, Kelley enthusiastically adopted the mantra of the first half of the 1990s. When the money ran out, so did his job. *Department of Public Affairs, University of Pennsylvania Health System.*

Judith Rodin, president of the University of Pennsylvania from 1994 and Kelley's nemesis. *Photo by Chet Snedden.*

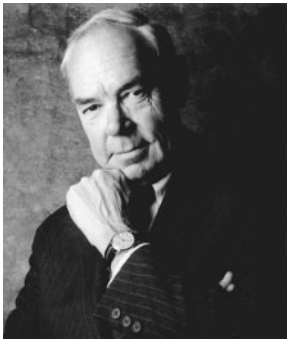
Although differing with each other on fundamental issues, Kelley and Rodin appeared affable and respectful in public. *Photo by Tommy Leonardi.*

Dr. Peter Traber, the gastroenterologist and molecular biologist who succeeded Kelley. An admirer described this former college football player as "a gentle giant you don't want to mess with." Traber resigned after five-and-a-half months in the job. *Photo by Karen Traber.*

Dr. Arthur Rubenstein, the "seasoned pro" whom Rodin chose to succeed Kelley and Traber as dean and executive vice president. By insisting that the head of the health system report to him, Rubenstein effectively eliminated the possibility that the clinical entities would separate from the university. *Photo by Tommy Leonardi.*

Robert Martin, in his office on the twenty-first floor of the "Tower of Power," followed Traber as CEO of the health system. When Martin announced he would leave, three people had held the CEO position in less than three years. *Photo by Tommy Leonardi.*

The original Johns Hopkins Hospital, with the Billings Building and its signature dome as the centerpiece. *The Alan Mason Chesney Medical Archives of the Johns Hopkins Medical Institutions.*



Dr. Robert Heyssel, the "grouchy old bear," who ruled the Johns Hopkins Hospital with great success from 1972 to 1992. *Photo by William Coupon.*

Dr. Richard Ross, dean of the Johns Hopkins University School of Medicine from 1975 to 1990. In the university president, Heyssel and Ross had a "common adversary to concentrate on." *Photo by J. K. Lightner, courtesy of the Alan Mason Chesney Medical Archives of the Johns Hopkins Medical Institutions.*

"Thick as thieves" were Drs. Michael Johns (left) and James Block in happier times soon after Block arrived at Hopkins. The brilliant and creative Block led the Johns Hopkins Hospital and Health System from 1992 to 1996, but his critics maintained that "Jim just didn't get it," that he never fully imbibed the Hopkins culture. Johns's resignation as dean of the medical school in 1995 initiated the actions that led to the most significant change in the governance of the Johns Hopkins hospital and medical school since their founding. *The Alan Mason Chesney Medical Archives of the Johns Hopkins Medical Institutions.*

Dr. Edward Miller, the quiet anesthesiologist "without baggage, an outside-inside kid," who became the first dean/CEO of Johns Hopkins Medicine. *Photo by Gary Jackson.*

Ronald Peterson, the calm, deliberate president of the hospital and health system after Block, who was comfortable working as number 2 for the dean/CEO. *The Alan Mason Chesney Medical Archives of the Johns Hopkins Medical Institutions.*

William Richardson, the university president from 1992 to 1996. The conflict between Block and Johns contributed to his leaving Hopkins. *The Alan Mason Chesney Medical Archives of the Johns Hopkins Medical Institutions.*

Dr. William Brody, the radiologist whom Hopkins elected president after Richardson. Although eschewing the title "doctor," he significantly influenced developments in East Baltimore. *Photo by Doug Barber for the Johns Hopkins University.*

The trustee committee that constructed Johns Hopkins Medicine. (Left to right, top) Robert Heyssel (consultant), Michael Armstrong, Lenox Baker, Furlong Baldwin. (Middle) Donald Shepard, Shale Stiller, Toby Gordon (staff). (Bottom) Alvin Krongard, George Bunting (co-chairman), Morris Offit (co-chairman), Michael Bloomberg, Edward Dunn. *Photo by Ben Renwick, Facility and Operations Coordinator. Courtesy of the Alan Mason Chesney Medical Archives of the Johns Hopkins Medical Institutions.*

APPENDIX 1

Governance of American Academic Medical Centers

Medical Schools[a]	Teaching Hospitals[b]
PRIVATELY OWNED MEDICAL SCHOOLS	
Privately Owned Teaching Hospitals, Common Ownership, Head of Hospital Reports to Dean	
Howard	Howard University Hospital
Pennsylvania	Hospital of the University of Pennsylvania
Temple	Temple University Hospital
Privately Owned Teaching Hospitals, Common Ownership, Head of Hospital Does Not Report to Dean	
Albany[4]	Albany Medical Center Hospital
Emory[2]	Emory University and Crawford Long hospitals
Loma Linda[5]	Loma Linda University Medical Center
Pittsburgh[6]	University of Pittsburgh Medical Center
Rochester	Strong Memorial Hospital
Vanderbilt	Vanderbilt University Medical Center
Privately Owned Teaching Hospitals, Common Ownership, Dean Reports to Person or Organization That Owns the Hospital	
Mayo[7]	Saint Mary's Hospital; Rochester Methodist Hospital[c]
Rush[d]	Rush-Presbyterian-St. Luke's Medical Center

Privately Owned Teaching Hospitals, Different Ownership[e]

Albert Einstein	Montefiore Medical Center
Baylor	Methodist Hospital
Boston	Boston Medical Center
Brown	Rhode Island Hospital
Case Western Reserve	University Hospitals of Cleveland
Chicago	University of Chicago Hospitals[f]
Chicago Medical[10]	Mount Sinai Hospital Medical Center
Columbia	NewYork–Presbyterian Hospital
Cornell	NewYork–Presbyterian Hospital
Creighton	St. Joseph Hospital (for-profit)
Dartmouth	Mary Hitchcock Memorial Hospital
Duke	Duke University Hospital[g]
George Washington	George Washington University Hospital (for-profit)
Georgetown	Georgetown University Hospital
Harvard	Massachusetts General Hospital + others[12]
Jefferson[13] [h]	Thomas Jefferson University Hospital
Johns Hopkins[i]	Johns Hopkins Hospital
Loyola[14]	Loyola University Medical Center
Drexel University College of Medicine (formerly MCP-Hahnemann)	Hahnemann University Hospital (for-profit)
	MCP Hospital (for-profit)
Mercer[15]	Medical Center of Central Georgia, Macon
	Memorial Health University Medical Center, Savannah
Mount Sinai[16] [j]	Mount Sinai Hospital
Northwestern	Northwestern Memorial Hospital
Penn State[17]	Milton S. Hershey Medical Center[k]
St. Louis	St. Louis University Hospital (for-profit)
Stanford University[l]	Stanford University Hospital
Tufts	New England Medical Center, Inc.
Tulane	Tulane University Hospital and Clinic (for-profit)
Wake Forest	North Carolina Baptist Hospitals, Inc.
Washington, St. Louis	Barnes-Jewish Hospital

Wisconsin, Medical College of	Froedtert Memorial Lutheran Hospital
Yale[19]	Yale-New Haven Hospital

Government-Owned Teaching Hospitals

Chicago Medical	Cook County Hospital (County)
Emory	Grady Memorial Hospital (County)
Meharry[20]	Metropolitan Nashville General Hospital (County)
Miami	Jackson Memorial Hospital (County)
Morehouse	Grady Memorial Hospital (County)
New York	Bellevue Hospital (City)
New York Medical College	Westchester Medical Center (County)
Southern California[21]	Los Angeles County USC Medical Center (County)
Tulane	Medical Center of Louisiana at New Orleans (State)

GOVERNMENT-OWNED MEDICAL SCHOOLS[m]

Government-Owned Teaching Hospitals, Common Ownership, Head of Hospital Reports to Dean

Connecticut	John Dempsey Hospital, University of Connecticut Health Center
Iowa	University of Iowa Hospital & Clinics
Louisiana State University, Shrevesport[22]	Louisiana State University Hospital
New Jersey, Newark[23]	University Hospital
Mississippi	University Hospitals and Clinics University of Mississippi Medical Center
North Carolina	University of North Carolina Hospitals
Ohio State	Ohio State University Hospitals
South Alabama	University of South Alabama Medical Center
Los Angeles, California[24]	University of California, Los Angeles Medical Center
San Diego, California	University of California, San Diego Medical Center

Utah	University of Utah Hospital
Washington, Seattle	University of Washington Medical Center[25]

Government-Owned Teaching Hospitals, Common Ownership, Head of Hospital Does Not Report to Dean

Alabama at Birmingham	University of Alabama Hospitals
Arkansas	University Hospitals of Arkansas
Brooklyn, SUNY	University Hospital of Brooklyn
Davis, California[26]	University of California, Davis Medical Center
Irvine, California[27]	University of California, Irvine Medical Center
Illinois	University of Illinois Medical Center at Chicago
Kentucky	University of Kentucky Hospital
Louisiana State University, New Orleans[35]	Medical Center of Louisiana (formally Charity Hospital) (State)[n]
Louisville[28]	University of Louisville Health Care University Hospital
Michigan	University of Michigan Medical Center
Ohio, Medical College of, Toledo	Medical College of Ohio Hospitals
Oregon	Oregon Health Sciences University Hospital
South Carolina, Medical University of	Medical University of South Carolina Medical Center
Stony Brook, SUNY[29]	University Hospital, SUNY, Health Sciences Center, Stony Brook
Syracuse, SUNY	University Hospital, SUNY, Health Sciences Center, Syracuse
Texas, Galveston	University of Texas Medical Branch Hospital
San Francisco, California[30,31]	University of California, San Francisco Medical Center
Uniform Services, USUHS[31] [o]	Walter Reed Army Medical Center[p] National Naval Medical Center
Virginia[32]	University of Virginia Health System

Teaching Hospitals Owned by Governments Different from Medical School

Colorado[q]	University of Colorado Hospital (State authority)
East Carolina	Pitt County Memorial Hospital (County)
Georgia, Medical College of[34]	Medical College of Georgia Health, Inc. (State)
Kansas	Kansas University Hospital (State)
New Jersey, Robert Wood Johnson[29]	Robert Wood Johnson University Hospital
Missouri, Columbia	University of Missouri Hospital and Clinics (State)
Nevada[36]	University Medical Center, Las Vegas (County)
New Mexico	University of New Mexico Hospital (State)
Texas, San Antonio	University Health System (State)
Texas, Southwestern, Dallas	Parkland Health & Hospitals System (County)
Virginia, Medical College of	Medical College of Virginia Hospitals (Hospital District)
Washington, Seattle	Harborview Medical Center (County)[1]

Privately Owned Teaching Hospitals

Arizona[37]	University Medical Center
Buffalo, SUNY[2,38]	Buffalo General Hospital System
Cincinnati	University Hospital
East Tennessee[39]	Community hospital groups
Eastern Virginia[40]	Sentara Norfolk General Hospital
Florida[41 r]	Shands Hospital
Hawaii[19]	Queen's Medical Center
Illinois, Southern[42]	Community hospitals
Indiana[2,43]	Clarian Health Systems
Marshall[44]	Community hospitals
Maryland	University of Maryland Medical System
Massachusetts[45]	UMass Memorial Medical Center
Michigan State	Community hospitals

Minnesota, Duluth[46 s]	Community hospitals
Minnesota[2]	Fairview-University Medical Center
Missouri, Kansas City	Truman Medical Center Hospital Hill
Nebraska[47]	Nebraska Health System
Nevada[36]	Community hospitals
North Dakota[48]	Community hospitals
Ohio, Northeastern, Rootstown[49]	Community hospitals
Oklahoma	University Health Partners (for-profit)
South Carolina[50]	Palmetto Richland Memorial Hospital
South Dakota[51]	Community hospitals
South Florida[52]	Tampa General Hospital
Tennessee	Regional Medical Center at Memphis
Texas A & M	Scott & White Memorial Hospital
Texas Tech[53]	Community hospitals
Texas, Houston	Memorial Herman Hospital
Vermont	Fletcher Allen Health Care
Wayne State[54]	Detroit Medical Center
West Virginia[55]	West Virginia University Hospitals
Wisconsin	University of Wisconsin Hospital and Clinics
Wright State[56]	Miami Valley Hospital

Source: Much of the information in this table was provided from data maintained at the Association of American Medical Colleges.[2,3] For additional data, I contacted leaders at the schools (see notes). Most of this table was prepared in February 2002 and completed in September 2002.

Note: Although most medical schools are affiliated with more than one hospital, only the largest hospital, with a few exceptions, where the teaching is conducted for each school is listed. Relationships with Veterans Administration hospitals are not included even though VA hospitals are important affiliates of many schools and the primary affiliates of a few.[1]

[a]Listed by their commonly recognized names; "university" usually omitted.

[b]Hospitals are not-for-profit except as noted.

[c]Both of these hospitals and the Mayo Medical School are owned by the Mayo Foundation.

[d]At Rush, the hospital owns the medical school, and the dean reports to the president of the hospital corporation.[8]

[e]Unless otherwise noted, the dean or the senior officer of the medical campus does not have direct authority over the hospital.

[f]The University of Chicago is the sole member of the not-for-profit corporation that owns the University of Chicago Hospitals. Although the hospital CEO works for the hospital corporation, university officers and trustees can exercise significant influence over his or her selection.[9]

[g]Duke University is the sole member of the separate corporation that owns the Duke University Hospital. Hence, the governance of the medical school and health system is functionally unified under the chancellor.[11]

[h]The president of Thomas Jefferson University is the chairman of the board of the Jefferson Health System, which owns Thomas Jefferson Hospital.

[i]The medical school and hospital are owned by different corporations but function together under one executive, the dean/CEO of Johns Hopkins Medicine (see chapter 6).

[j]Although the Mount Sinai Hospital is part of a merged corporation with the Tisch Hospital of New York University, the president of the Mount Sinai Medical Center exercises functional authority over the Mount Sinai Hospital (2002).

[k]The dean/CEO at Hershey has direct authority over the hospital as well as the medical school.

[l]The CEOs of Stanford University Hospital and Lucile Packard Children's Hospital report directly to the boards of trustees of their hospitals. The university is the sole member of each of these boards. With the dean of the school of medicine as chairman, the two CEOs and the dean constitute an executive committee for the medical center.[18]

[m]Each government-owned medical school is owned by a state, except for USUHS.

[n]Louisiana State University now owns the Medical Center of Louisiana. The hospital CEO reports (indirectly) to the chancellor of the Health Sciences Center, not to the dean.

[o]Federally owned medical school.

[p]Federally owned teaching hospital.

[q]The chancellor of the University of Colorado Health Science Center chairs the board of the University of Colorado Hospital.[33]

[r]The vice-president for health affairs of the University of Florida School of Medicine chairs the board of Shands Hospitals.

[s]The medical school in Duluth is a two-year school, and the University of Minnesota at Minneapolis awards the M.D. degrees. Some students take their clinical clerkships in community hospitals in Duluth.

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Interviewees

University of Pennsylvania

Note: CEO = Chief Executive Officer, CPUP = Clinical Practices of the University of Pennsylvania, HUP = Hospital of the University of Pennsylvania, PAH = Pennsylvania Hospital, PHH = Phoenixville Hospital, PRH = Presbyterian Hospital, UP = University of Pennsylvania, UPHS = University of Pennsylvania Health System, UPSM = University of Pennsylvania School of Medicine. Titles without dates are those held when this appendix was prepared in the summer of 2002. Appointments at Penn are listed first. Institutions are in Philadelphia, unless otherwise indicated.

Name	*Position*
Adler, Betty S., J.D.	Senior Counsel, UP
Altschuler, Steven M., M.D.	CEO, Children's Hospital of Philadelphia
Asbury, Arthur K., M.D.	Acting Dean, UPSM & Acting Executive Vice-President, UP (2000–2001)
Ball, John R., M.D., J.D.	President & CEO, PAH (1996–1999)
Ballam Jr., Samuel H.	Chairman, Health Affairs Committee, UP Board of Trustees (1972–1987)
Barchi, Robert L., M.D., Ph.D.	Provost, UP
Barg, Ronald B., M.D.	Senior Medical Director, Clinical Care Associates, UPHS; Chief Medical Officer, PHH (2000–2002)
Barker, Clyde F., M.D.	Chairman, Department of Surgery, UPSM (1983–2001)
Baum, Stanley, M.D.	Chairman, Department of Radiology, UPSM (1975–1996)

Beeman, Thomas E.	Senior Vice-President, Hospital Operations, UPHS & Executive Director, HUP (1997–1999); President & CEO, Saint Thomas Health Services, Nashville, TN
Bennett, J. Claude, M.D.	President and Chief Operating Officer, BioCryst Pharmaceutical, Birmingham, AL; Chairman, Department of Medicine, University of Alabama at Birmingham (UAB) (1982–1993); President, UAB (1993–1996)
Berkowitz, Henry D., M.D.	Chief, Division of Vascular Surgery, PRH (1991–1996); Chairman, Division of Vascular Surgery, Albert Einstein Medical Center
Black, Michael E.	Vice-Dean for Administration & Finance, UPSM
Bloom, Bernard S., Ph.D.	Research Professor of Medicine, UPSM
Blutt, Mitchell J., M.D.	Trustee, UP; Executive Partner, Chase Capital Partners, New York
Bowman, Marjorie A., M.D.	Chair, Department of Family Practice & Community Medicine, UPSM
Brown Jr., Richard P., J.D.	Emeritus Trustee, UP; Counsel, Morgan, Lewis & Bockius, LLP
Bryan, R. Nick, M.D.	Chairman, Department of Radiology, UPSM
Buckley Jr., R. Michael, M.D.	Chairman, Department of Medicine, PAH
Burbank, Stephen B., J.D.	David Berger Professor for the Administration of Justice, UP Law School
Burg, Fredric D., M.D.	Vice-Dean for Education, UPSM (1989–1995); Director, University of Alabama at Birmingham Health Center/Huntsville
Burns, Lawton Robert, Ph.D.	Director, Wharton Center for Health Management & Economics, Wharton School, UP
Caplan, Arthur L., Ph.D.	Director, Center for Bioethics, UPSM
Catherwood, Susan W.	Trustee, UP
Catton, Raymond M., M.D.	Chairman, Department of Psychiatry, PHH
Chance, Britton, Ph.D.	Emeritus Professor of Biochemistry & Biophysics, UPSM

Colling, Dennis	Associate Vice-President, UPHS (1993–1994); Vice-President, Partners HealthCare System, Inc., Boston, MA
Cox, Malcolm, M.D.	Associate Dean, Director of Network & Primary Care Education, UPSM
Daddis, John A.	Senior Vice-President, Managed Care & Operations, Independence Blue Cross
Davies, Helen Conrad, Ph.D.	Professor of Microbiology, UMSM
DeAngelis Jr., Peter L.	Chief Financial Officer, UPHS
DiBona, G. Fred	CEO, Independence Blue Cross
Dreyfus, Gideon, Ph.D.	Investigator, Howard Hughes Medical Institute; Professor of Biochemistry & Biophysics, UPSM
Dutton, P. Leslie, Ph.D.	Chairman, Department of Biochemistry & Biophysics, UPSM
Eisner, Joel W., M.D.	Clinical Professor of Medicine, UPSM; Associate Dean for Regional Clinical Development, UPHS (1994–2001)
Emerson Jr., Charles P.	Chairman, Department of Cell & Developmental Biology, UPSM
Ende, Jack, M.D.	Chief of Medicine, PRH
Engelman, Karl, M.D.	Chief, Hypertension Division, UPSM (1970–1996)
Evans, Dwight L., M.D.	Chairman, Department of Psychiatry, UPSM
Fagin, Claire M., Ph.D.	Interim President, UP (1993–1994)
Ferniany, I. William, Ph.D.	Senior Vice-President, Administrative & Network Services, UPHS
Field, Robert I., Ph.D., J.D.	With UPHS (1994–1999); Senior Director for Planning and Business Development, UPHS (1998–1999); Director, Graduate Program in Health Policy, University of the Sciences in Philadelphia
Fishman, Alfred P., M.D.	Senior Associate Dean, UPSM
Fitts, Michael A., J.D.	Dean, UP Law School
FitzGerald, Garret A., M.D.	Chairman, Department of Pharmacology, UPSM
Foley, William T.	Senior Vice-President for Hospital Operations, UPHS (1995–1997); President & CEO, Catholic Healthcare West Arizona, Phoenix

Fox, Robert A.	Trustee, UP; President & Chairman, R.A.F. Industries
Fry, John A.	Executive Vice-President, UP (1995–2002); President, Franklin & Marshall College, Lancaster, PA
Gellhorn, Alfred, M.D.	Dean, UPSM (1967–1973); Chairman, Advisory Board, Gateway to Higher Education, New York
George, Michael	Chief Operating Officer, Penn Medicine at Radnor, UPHS
Glick, John H., M.D.	Director, Cancer Center, UPSM
Goldfarb, Stanley, M.D.	Interim Chair, Department of Medicine, UPSM (2000–2002)
Gonatas, Nicholas K., M.D.	Chairman, Search Committee for Dean, UPSM & Executive Vice-President, UP Medical Center (1987–1989)
Goodman, David B. P., M.D., Ph.D.	Director, Endocrinology Laboratory, HUP
Goodman, Robert L., M.D.	Chairman, Department of Radiation Oncology, UPSM (1977–1990); Acting Executive Director, HUP (1985–1987); Chairman, Radiation Oncology, St. Barnabas Medical Center & Northern Division of St. Barnabas Health Care System, Livingston, NJ
Grippi, Michael A., M.D.	Associate Professor of Medicine, UPSM; Medical Director, Penn Medicine at Radnor UPHS (1996–1999)
Gross, Larry, Ph.D.	Professor of Communications, Annenberg School, UP; President, Faculty Senate, UP (2000–2001)
Hackney, Sheldon, Ph.D.	Professor of History, UP; President, UP (1981–1993)
Hansen-Flaschen, John, M.D.	Chief, Pulmonary, Allergy & Critical Care Division, UPSM; Chair, Medical Faculty Senate Steering Committee, UPSM (1997–1998)
Harkins Jr., John G., J.D.	Trustee, UP; Partner, Harkins Cunningham
Harris, C. Martin, M.D.	Associate Vice-President and Chief Information Officer, UPHS (1993–1996); Chief Information Officer, Cleveland Clinic Foundation
Henson, Douglas E.	Senior Vice-President for Professional Services, UPHS

Hillman, Alan L., M.D.	Director, Center for Health Policy, Leonard Davis Institute of Health Economics, Wharton School, UP
Hirshfeld, John W., M.D.	Director, Cardiac Catheterization Laboratories, HUP
Holmes, Edward W., M.D.	Chairman, Department of Medicine, UPSM (1991–1997); Dean & Vice-Chancellor for Health Sciences, University of California, San Diego
Howell, Joel D., M.D., Ph.D.	Director, Program in Society & Medicine, University of Michigan School of Medicine, Ann Arbor
Jacobson, Gerald J.	Principal, HealthCare Assets, Wyncote, PA
Jarett, Leonard, M.D.	Chairman, Department of Pathology & Laboratory Medicine, UPSM (1980–1999)
Kaludis, George, Ph.D.	Chairman & President, Kaludis Consulting Group, Washington, DC
Katz, Gerald	President, The Katz Consulting Group, Inc., Plymouth Meeting, PA
Kazazian Jr., Haig H., M.D.	Chairman, Department of Genetics, UPSM
Kelley, Mark A., M.D.	Vice-Dean for Clinical Affairs, UPSM (1990–1999); Vice-Chair, Department of Medicine, UPSM & Chief of Medicine, Philadelphia Veterans Affairs Medical Center (1999–2000); Executive Vice-President & Chief Medical Officer, Henry Ford Health System; Chief Executive Officer, Henry Ford Medical Group, Detroit
Kelley, William N., M.D.	Professor of Medicine, UPSM; Executive Vice-President, UP & Dean, UPSM (1989–2000); CEO, UP Medical Center (1989–2000) & UPHS (1993–2000)
Kepner, John C. S., J.D.	Senior Vice-President for Network Development & Executive Director for Clinical Care Associates UPHS (1993–1999); President, Fenway Health Management Advisors, King of Prussia, PA; Partner, Tsoules, Sweeney & Kepner, LLC, Exton, PA

Kerr, Gavin	With UPHS (1995–2000), Vice-President, Planning & Organization Effectiveness, UPHS (1999–2000); President & CEO, Mercy Health System, Conshohocken, PA
Kissick, William L., M.D.	George S. Pepper Professor Emeritus of Public Health and Preventive Medicine in Molecular and Cellular Engineering, UPSM; Chairman, Department of Community Medicine, UPSM (1968–1971)
Langenberg, Donald N., Ph.D.	Trustee, UP (1990–2000); Chancellor, University System of Maryland (1990–2002)
Langfitt, Thomas W., M.D.	Vice-President for Health Affairs, UP (1973–1987)
Laties, Alan M., M.D.	Scheie-Mackall Research Professor of Ophthalmology, UPSM
Lavizzo-Mourey, Risa, M.D.	Chief, Division of Geriatric Medicine & Director, Institute on Aging, UPSM (1994–2001); President & CEO, The Robert Wood Johnson Foundation, Princeton, NJ
Levitan, Mark S.	Executive Director, HUP (1974–1982)
Longnecker, David E., M.D.	Chairman, Department of Anesthesia, UPSM; Vice-Dean for Professional Services, UPSM
Mahoney, Kevin B.	Executive Director, PHH; Executive Director, Clinical Care Associates, UPHS (1999–2002)
Marchlinski, Francis E., M.D.	Director, Cardiac Electrophysiology, UPHS
Marsh, Martha H.	Vice-President for Managed Care & Senior Vice-President for Professional Services & Managed Care, UPHS (1994–1998); President & Chief Executive Officer, Stanford Hospital & Clinics, Stanford, CA
Martin, Robert D., Ph.D.	CEO, UPHS; Chief Financial Officer, then Chief Operating Officer, UPHS (1997–2001)
Mastroianni, Luigi, M.D.	Professor of Obstetrics & Gynecology; Chairman, Department of Obstetrics & Gynecology, UPSM (1965–1987)

Matschinsky, Franz M., M.D.	Benjamin Rush Professor of Biochemistry & Biophysics; Chairman, Department of Biochemistry & Biophysics, UPSM (1984–1993)
McDonald, Walter J., M.D.	Executive Vice-President, American College of Physicians/American Society of Internal Medicine
McKenna, W. Gillies, M.D.	Chairman, Department of Radiation Oncology, UPSM
Mennuti, Michael T., M.D.	Chairman, Department of Obstetrics & Gynecology, UPSM
Meyerson, Martin, Ph.D.	President, UP (1970–1981)
Miller Jr., Paul F.	Chairman, Board of Trustees, UP (1978–1986)
Molinoff, Perry B., M.D.	Chairman, Department of Pharmacology, UPSM (1981–1994); Executive Vice-President, Research & Development, Palatin Technologies, Edison, NJ
Morrison, Gail, M.D.	Vice-Dean for Education, UPSM
Mulhern, Victoria A.	Director, Faculty Affairs, UPSM
Nash, David B., M.D.	Director, Health Policy & Clinical Outcomes, Thomas Jefferson University Hospital; Associate Dean for Health Policy, Jefferson Medical College
Nathanson, Neal, M.D.	Vice-Provost for Research, UP
Nemzoff, Joshua A.	President, Nemzoff & Co., New Hope, PA
Notebaert, Edmond F.	President, Children's Hospital of Philadelphia (1987–2000)
Nowell, Peter C., M.D.	Gaylord P. Harnwell Professor of Pathology & Laboratory Medicine, UPSM
Otten, Jeffrey	Chief Operating Officer, HUP (1991–1993)
Owens, Gary M.	Vice-President, Patient Care Management, Independence Blue Cross
Palmer, Russell E.	Trustee, UP; Chairman & CEO, The Palmer Group; Chairman, Executive Committee, Health System Trustee Board (1999–2001)
Parmacek, Michael S., M.D.	Chief, Cardiovascular Division, UMSM
Pauly, Mark V., Ph.D.	Chairman, Health Care Systems Department, Wharton School, UP

Peck, William A., M.D.	Executive Vice-Chancellor for Medical Affairs, Washington University; Dean, Washington University School of Medicine, St. Louis
Piper, Arthur H.	Chief Financial Officer, HUP (1976–1989)
Pitt, Bertram, M.D.	Associate Chair for Industrial & Academic Affairs, University of Michigan, Ann Arbor
Pittinger, Wilbur B.	Executive Director, HUP (1989–1995); Senior Vice-President, Health Services, UPHS (1993–1995); Vice-President of Operations, Clinical Sciences & Product Development, Merck & Co., Inc., Rahway, NJ
Quinn, Peter D., D.M.D., M.D.	Chairman, Department of Oral & Maxillofacial Surgery, UPSM; Chairman, Medical Board, HUP (1999–2000)
Ramsden, Elsa S., Ed.D.	Associate Professor Emeritus, UP; President, American Association of University Professors (1990–2000)
Reitz, Curtis R., LL.B.	Algernon Sydney Biddle Professor of Law, UP Law School; Provost & Vice-President, UP (1971–1972)
Relman, Arnold S., M.D.	Chairman, Department of Medicine, UPSM (1968–1977); Professor Emeritus of Medicine & Social Medicine, Harvard Medical School, Boston; Editor-in-Chief Emeritus, *New England Journal of Medicine,* Boston
Rhoads, Jonathan E., M.D.	Chairman, Department of Surgery (1959–1972), UPSM; Provost, UP (1956–1959)
Riepe, James S.	Chairman, Board of Trustees, UP; Vice-Chairman, T. Rowe Price Associates, Inc., Baltimore
Rodin, Judith S., Ph.D.	President, UP
Rogers, Paul H., M.D.	Senior Medical Director, Clinical Care Associates, UPHS
Rosengard, Bruce R., M.D.	Assistant Professor of Surgery, UPSM
Rowland, Lewis P., M.D.	Chairman, Department of Neurology, UPSM (1967–1973); Professor of Neurology, Columbia University College of Physicians & Surgeons, New York

Rubenstein, Arthur H., M.B., B.Ch.	Dean, UPSM; Executive Vice-President, UP for the UPHS
Saunders, James C., Ph.D.	Professor of Research Otorhinolaryngology & Physiology, UPSM; Professor of Neuroscience, UPSM
Schaffer, Priscilla A., Ph.D.	Chair, Department of Microbiology, UPSM (1996–2001); Professor of Medicine (Microbiology & Molecular Genetics), Harvard Medical School, Boston
Scheib, Garry L.	Executive Director, HUP
Schnabel, Truman G., M.D.	C. Mahlon Kline Emeritus Professor of Medicine, UPSM
Schwartz, C. Edward	Executive Director, HUP (1987–1989)
Schwartz, J. Sanford, M.D.	Professor of Medicine, UPSM; Professor of Health Management & Economics, Wharton School, UP
Scolnick, Edward M., M.D.	Executive Vice-President Science & Technology, Merck & Company, Inc., West Point, PA
Seagrave, Richard E.	President & Chief Executive Officer, PHH (1989–1997); Executive Director/Chief Operating Officer, PHH/UPHS (1997–2000)
Seegmiller, J. Edwin, M.D.	Research Professor of Medicine, University of California, San Diego; Associate Director, Stein Institute for Research on Aging
Segal, Bernard L., M.D.	Director, Philadelphia Heart Institute, PRH (1986–1996); Director, Division of Cardiology, Thomas Jefferson University Hospital
Silberberg, Donald H., M.D.	Senior Associate Dean, Director International Medical Programs, UPSM
Stemmler, Edward J., M.D.	Dean Emeritus, UPSM; Dean, UPSM (1975–1988); Executive Vice-President, UP (1986–1989)
Stinnett, James L., M.D.	Professor of Psychiatry, UPSM; Acting Executive Director, CPUP, UPSM (1989); Acting Vice-Dean, Clinical Affairs, UPSM (1989–1990)
Stone, Richard A., M.D.	Vice-Chairman for Research, Department of Ophthalmology, UPSM

Strom, Brian L., M.D.	Chairman, Department of Biostatistics & Epidemiology, UPSM
Stunkard, Albert J., M.D.	Professor of Psychiatry, UPSM; Chairman, Department of Psychiatry, UPSM (1962–1973); Interim Chairman, Department of Psychiatry, UPSM (1996–1997)
Sussman, Elliot J., M.D.	Executive Director, CPUP, UPSM (1987–1989); Chairman of the Board & President, PennCARE, Inc., Allentown, PA; President & CEO, Lehigh Valley Hospital & Health Network, Inc., Allentown, PA
Tanenbaum, Myles H., J.D.	Trustee, UP; Chairman, Arbor Enterprises, West Conshohocken, PA
Tannen, Richard L., M.D.	Senior Vice-Dean, UPSM (1995–2002)
Traber, Peter G., M.D.	Interim Dean, UPSM (2000); CEO, UPHS (2000); President & CEO, Baylor College of Medicine, Houston, TX
Vagelos, P. Roy, M.D.	Chairman, Board of Trustees, UP (1994–1999); CEO (1985–1994), Chairman (1986–1994), Merck & Co., Inc., Rahway, NJ
Van Dusen, Duncan W.	Associate Secretary, UP
Volpe, Michele M.	Executive Director, PRH
Wasserstein, Alan G., M.D.	Vice-Dean for Faculty Affairs, UPSM; Chair, Medical Faculty Senate Steering Committee, UPSM (2000–2001)
Waxman, Harvey L., M.D.	Chief of Cardiology, PRH
Welsh, Raymond H.	Trustee, UP; Senior Vice-President, Paine-Webber, Inc.
Whittington, Marna C., Ph.D.	Executive Vice-President, UP (1984–1992)
Wiesenthal, Steven M.	Associate Vice-President, Architecture & Facilities Management, UPHS (1991–2000); Associate Vice-Chancellor, Facilities Management, University of California, San Francisco
Wigglesworth, Andrew B.	President, Delaware Valley Healthcare Council
Williams, Barbara C.	Executive Assistant to the CEO/Dean, UPHS (1993–2001)

Williams, Gordon D.	Senior Vice-President for Academic and Clinical Affairs, UPHS & Vice-Dean for Administration, UPSM (1994–1996); Vice-President, UP Medical Center & Executive Director, UPSM (1990–1993); Vice-Dean for Administration and Finance, Duke University School of Medicine & Vice-Chancellor for Operations, Duke University Medical Center, Durham, NC
Williams, Henry C.	Director, Special Projects, UPHS & Secretary, Trustee Board, UPHS (1993–2001)
Williams, Sankey V., M.D.	Chief, Division of General Internal Medicine, UPSM
Worley, Richard B.	Member, Executive Committee, Trustee Board, UPHS (1989–1999)
Wyngaarden, James B., M.D.	Senior Associate Dean, International Programs, UPSM (1995–1997); Chairman, Department of Medicine, UPSM (1965–1967); Chairman, Department of Medicine, Duke University School of Medicine, Durham, NC (1967–1982); Director, National Institutes of Health, Bethesda, MD (1982–1989)
Yamada, Tadataka, M.D.	Chairman, Research and Development, SmithKline Beecham, King of Prussia, PA; Chairman, Department of Internal Medicine, University of Michigan School of Medicine, Ann Arbor (1990–1996)
Zamzow, John C.	Senior Vice-President, Contracting & Provider Networks, Independence Blue Cross

Johns Hopkins University and Hospital

Note: Bayview = Johns Hopkins Bayview Medical Center (formerly Baltimore City Hospitals & Francis Scott Key Medical Center), CEO = Chief Executive Officer, JHH = Johns Hopkins Hospital, JHHS = Johns Hopkins Health System, JHM = Johns Hopkins Medicine, JHU = Johns Hopkins University, JHUSM = Johns Hopkins University School of Medicine. Titles without dates are those held when this appendix was prepared in the summer of 2002. Institutions are in Baltimore, unless otherwise indicated.

Name	*Position*
Abeloff, Martin D., M.D.	Director, Department of Oncology, JHUSM
Achuff, Stephen C., M.D.	Director, Adult Cardiology Clinical Programs, JHH
Agnew, William S., Ph.D.	Director, Department of Physiology, JHUSM
Angell, Charles S., M.D.	Assistant Professor of Medicine, JHUSM
Armstrong, C. Michael	Trustee, JHU; CEO, AT&T
Baldwin, H. Furlong	Chairman, Board of Trustees, JHH (1989–1994); Chairman (1976–present), CEO (1976–2001), Mercantile Bankshares
Baughman, Kenneth L., M.D.	Director, Division of Cardiology, JHUSM (1992–2001)
Baumgartner, William A., M.D.	Cardiac Surgeon-in-Chief, JHH; President, Clinical Practice Association, JHUSM
Benz Jr., Edward J., M.D.	Director, Department of Medicine, JHUSM (1995–2000); President, Dana-Farber Cancer Institute; CEO, Dana-Farber/Partners CancerCare, Boston
Berg, Jeremy M., Ph.D.	Director, Department of Biophysics and Biophysical Chemistry, JHUSM
Blake, David A.	Executive Vice-Dean & Vice-Dean for Research, JHUSM, (1993–1996)
Block, James A., M.D.	President, JHH & JHHS (1992–1996)
Bloomberg, Michael R.	Chairman, Board of Trustees, JHU (1996–2002); Mayor, New York City
Brawley, Robert K., M.D.	Associate Professor of Surgery Emeritus, JHUSM
Brewster, Andre W., J.D.	Trustee Emeritus, JHH, JHHS, JHM, JHU; former chairman, Piper & Marbury

Brieger, Gert H., M.D., Ph.D.	Director, Department of History of Science, Medicine & Technology, JHU & JHUSM (1984–2002)
Broccolino, Victor	President & CEO, Howard County General Hospital, Columbia, MD
Brody, William R., M.D., Ph.D.	President, JHU
Bunting Jr., George L.	Chairman, Board of Trustees, JHH (1994–1998); President and CEO, Bunting Management Group, Timonium, MD
Cameron, John L., M.D.	Director, Department of Surgery, JHUSM
Chrencik, Robert A.	Executive Vice-President, Chief Financial Officer, University of Maryland Medical System, Baltimore
Clements, Janice E., Ph.D.	Vice-Dean for Faculty Affairs, JHUSM
Cohen, Harold A., Ph.D.	President, Hal Cohen, Inc.; Executive Director, Maryland Health Services Cost Review Commission (1972–1987)
Cummings, Charles W., M.D.	Director, Department of Otolaryngology, JHUSM
Daniel, Colene Y.	Vice-President, Corporate & Community Services, JHHS
Dembeck, Brian B.	Vice-President, Finance & Administration, Dome Corporation of JHHS
Dover, George J., M.D.	Director, Department of Pediatrics, JHUSM
Dunn Jr., Edward K.	Chairman, Board of Trustees, JHM, JHH, JHHS (1998–2002)
Fine, Ira T., M.D.	Assistant Professor of Medicine, JHUSM
Fortuin, Nicholas J., M.D.	Member, Board of Trustees, JHM
Freeman, Elaine	Executive Director, Communications and Public Affairs, JHM
Goldberg, Morton F., M.D.	Director, Department of Ophthalmology, JHUSM
Gordon, Toby A., Sc.D.	Vice-President, Planning & Marketing, JHM
Green, Gary B., M.D.	Chairman, Medical School Council, JHUSM (1996–1997)
Green, Warren	President & CEO, LifeBridge Health
Griffin, John W., M.D.	Director, Department of Neurology, JHUSM

Grossi, Richard A.	Chief Financial Officer, JHM
Halle, Edward A.	Senior Vice-President Emeritus, Administration, JHHS
Hellmann, David B., M.D.	Chairman, Department of Medicine, Bayview, JHUSM
Heyssel, Robert M., M.D.	Executive Vice-President & Director, JHH (1972–1983); President, JHH (1983–1986, 1988–1992); President, JHHS (1986–1992)
Hill, Barbara B.	President & CEO, The Johns Hopkins Health Plan, JHHS (1985–1991) President, Express Scripts, Inc., St. Louis
Hill, Martha N., Ph.D., R.N.	Dean, JHU School of Nursing
Jackson, J. Brooks, M.D.	Director, Department of Pathology, JHUSM
Jews, William L.	President and CEO, CareFirst, Inc.
Johns, Michael M. E., M.D.	Dean, JHUSM (1990–1996); Executive Vice-President for Health Affairs, Emory University
Johns, Richard J., M.D.	Distinguished Service Professor, Biomedical Engineering, JHUSM
Kelley, William N., M.D.	See Interviewees, University of Pennsylvania
Kelly, Thomas J., M.D., Ph.D.	Director, Department of Molecular Biology & Genetics, JHUSM (1982–2002); Director, Sloan-Kettering Institute, New York
Kent, William M.	Executive Vice-President & Chief Operating Officer, Executive Administration, Johns Hopkins Community Physicians, JHHS (1995–2002)
Klag, Michael J.	Director, Division of General Internal Medicine, JHUSM
Krongard, Alvin B. ("Buzzy")	Trustee, JHM, JHH, JHHS; Executive Director, Chief Operating Officer, Central Intelligence Agency, Langley, VA
Kues, Irvin W.	Senior Vice-President of Finance & Treasurer, JHH (1973–1993)
Lipstein, Steven H.	With JHH & JHHS (1982–1993); Vice-President, Administration, JHH (1993–1994); President & CEO, BJC Health Care, St. Louis

Lombardi, John V., Ph.D.	Provost, JHU (1988–1990); Professor of History, University of Florida
Long, Donlin M., M.D., Ph.D.	Director, Department of Neurosurgery, JHUSM (1973–2000)
Maffezzoli, Richard D., M.D.	Chief Financial Officer, CEO (1972–2002), Clinical Associates, Towson, MD
McGuirk Jr., William	Chairman, Board of Trustees, JHH (1972–1977)
McHugh, Paul R., M.D.	Director, Department of Psychiatry, JHUSM (1975–2001)
McKhann, Guy M., M.D.	Director, Mind Brain Institute, JHU
McKusick, Victor, M.D.	University Professor of Medical Genetics, JHUSM
Miller, Edward D., M.D.	Dean, JHUSM; CEO, JHM
Moses, Hamilton ("Chip")	Vice-President for Medical Affairs, JHH (1988–1993); Senior Adviser, Vice-President (Partner) and Director, The Boston Consulting Group, Boston
Mountcastle, Vernon B., M.D.	University Professor Emeritus of Neurosciences, JHU
Muller, Steven, Ph.D.	President, JHU (1972–1990); President, JHH (1972–1983)
Nichols, David G., M.D.	Vice-Dean for Education, JHUSM
Oakey, James A.	Consultant
Offit, Morris W.	Chairman, Board of Trustees, JHU (1990–1996); CEO, Offit Hall Capital Management, New York
Oken, Harry A., M.D.	Assistant Professor of Medicine, JHUSM; Clinical Associate Professor of Medicine, University of Maryland School of Medicine
Orens, Jonathan B., M.D.	Associate Professor of Medicine, JHUSM
Pasternak, L. Reuven, M.D.	Vice-Dean, Bayview, JHUSM
Peterson, Ronald R.	President, JHH; President, JHHS
Pollak, Joanne, J.D.	Vice-President, General Counsel, JHHS, JHM
Pollock, Stephen H., M.D.	Medical Director, Midatlantic Cardiovascular Associates, PA
Quandt, M. Denise	Vice-President, Operations, Johns Hopkins HealthCare, LLC, JHM
Reitz, Judy A., Sc.D.	Senior Vice-President, Operations, JHH; Vice-President, Operations Integration, JHHS

Richardson, William C., Ph.D.	President, JHU (1990–1995); President & CEO, W. K. Kellogg Foundation
Rogers, Mark C., M.D.	Director, Department of Anesthesiology and Critical Care Medicine, JHUSM (1980–1992); President & CEO, Paramount Capital, New York
Rosenstein, Beryl J., M.D.	Vice-President, Medical Affairs, JHH
Ross, Richard S., M.D.	Dean, JHUSM (1975–1990)
Rudikoff, Michael A., M.D.	Member, The Health Associates
Sabatini, Nelson J.	Executive Vice-President, Community Hospital Integration & Regional System Development, University of Maryland Medical System
Sachs, Murray B., Ph.D.	Director, Department of Biomedical Engineering
Sauder, W. Ronald	Senior Associate Director, Media Relations, JHUSM, JHHS (1994–1996); Director of Media Relations for the Health Sciences, Emory University
Scavo, Alton J.	Trustee, Howard County General Hospital, Columbia, MD; Trustee, JHM; Senior Vice-President, The Rouse Company, Columbia
Seidel, Henry M., M.D.	Professor Emeritus of Pediatrics, JHUSM
Shealer Jr., G. Daniel, J.D.	Deputy General Counsel, JHHS, JHM
Snyder, Solomon H., M.D.	Director, Department of Neurosciences, JHUSM
Sommer, Alfred, M.D.	Dean, Bloomberg School of Public Health, JHU
Stiller, Shale D., LL.B.	Trustee, JHM, JHU; Partner, Piper Rudnick LLP
Stobo, John D., M.D.	Director, Department of Medicine, JHUSM (1982–1994); Chairman & CEO, Johns Hopkins HealthCare, LLC (1994–1997); President, University of Texas Medical Branch, Galveston
Sunshine, Eugene S.	Senior Vice-President, Administration, JHU (1988–1997); Senior Vice-President for Business & Finance, Northwestern University, Evanston, IL
Turner, Thomas B., M.D.	Dean, JHUSM (1957–1968)
Walsh, Patrick C., M.D.	Director, Department of Urology, JHUSM
Watkins Jr., Levi	Associate Dean, Postgraduate Programs, JHUSM
Wegener, Stephen T., Ph.D.	Chairman, Medical School Council, JHUSM

Weisfeldt, Myron L., M.D.	Director, Department of Medicine, JHUSM
Werthman, Ronald J.	Vice-President, Finance & Administration, JHHS
White, Christine H.	Assistant Dean for Medicine, JHUSM
Wilczek, Kenneth P.	Executive Director, Clinical Practice Association, JHUSM
Wylie, Walker G.	Vice-President, Operations, Broadway Medical Management Corporation, JHHS
Yurow, Hank	CEO, Midatlantic Cardiovascular Associates, PA
Zamoiski Jr., Calman J.	Trustee, JHU, JHH
Zeller, John H.	Executive Director, Fund for Johns Hopkins Medicine, JHM
Zerhouni, Elias, M.D.	Executive Vice-Dean, JHUSM (1997–2002); Director, Department of Radiology, JHUSM (1996–2002); Director, National Institutes of Health
Zieve, Philip D., M.D.	Vice-President, Medical Affairs, Bayview; Chairman, Department of Medicine, Bayview (1973–2000)

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Notes

Preface

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CHAPTER ONE: Introduction

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15. Relman, Arnold S., M.D. Boston, by telephone 11/7/00 & 2/1/01.
16. Stemmler, Edward J., M.D. Roseland, VA, by telephone 5/8/00 & 1/3/01.
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27. Baum, Stanley, M.D. Philadelphia, 4/18/00, by telephone 2/5/01.
28. Hackney, Sheldon, Ph.D. Martha's Vineyard & Philadelphia, by telephone 6/2/00, by e-mail 1/31/01.
29. Miller Jr., Paul F. West Conshohocken, PA, 1/18/01.
30. Ballam Jr., Samuel H. Bryn Mawr, PA, 11/30/00.
31. Levitan, Mark S. Villa Nova, PA, 11/30/00.
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37. Burg, Frederic D., M.D. Huntsville, AL, by telephone 1/15/01.
38. Jarett, Leonard, M.D. Philadelphia, 4/25/00.
39. Silberberg, Donald H., M.D. Philadelphia, 4/18/00, by telephone 9/11/00.
40. Bennett, J. Claude, M.D. Birmingham, by telephone 9/7/00.
41. Gonatas, Nicholas K., M.D. Philadelphia, 11/5/00, by telephone 11/8/00 & 2/6/01.
42. Peck, William A., M.D. St. Louis, by telephone 10/20/00.
43. Whittington, Marna C., Ph.D. West Conshohocken, PA, 10/5/00.
44. Nowell, Peter C., M.D. Philadelphia, 6/6/00.

45. Stinnett, James L., M.D. Philadelphia, by telephone 6/21/00.
46. Asbury, Arthur K., M.D. Philadelphia, 10/4/00.
47. Hillman, Alan L., M.D. Philadelphia, by telephone 4/17/00.
48. Fishman, Alfred P., M.D. Philadelphia, 8/7/00.
49. Kelley, Mark A., M.D. Philadelphia, 4/25/00, by telephone 10/13/00.
50. Sussman, Elliot J., M.D. Allentown, PA, by telephone 6/9/00.
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8. DiBona Jr., G. F., Esq. Philadelphia, 11/29/00.
9. Zamzow, John C. Philadelphia, 11/29/00.
10. Katz, Gerald. Plymouth Meeting, PA, 12/21/00.
11. Owens, Gary M., M.D. Philadelphia, 11/29/00.
12. Nash, David B., M.D. Philadelphia, by telephone 1/19/01.
13. Van Dusen, Duncan W. Philadelphia, by telephone 11/10/00 & 11/17/00.
14. Goldfarb, Stanley, M.D. Philadelphia, 4/18/00, by telephone 10/30/00.
15. Kelley, Mark A., M.D. Philadelphia, 4/25/00, by telephone 10/13/00.
16. Schwartz, Edward. Chicago, by telephone 10/24/00.
17. Yamada, Tadataka, M.D. King of Prussia, PA, by telephone 9/9/00.
18. Pittinger, Wilbur B. Indianapolis, by telephone 9/13/00.
19. Hillman, Alan L., M.D. Philadelphia, by telephone 4/17/00.
20. Otten, Jeffrey. Boston, by telephone 9/20/00.
21. Kelley, William N., M.D. Philadelphia & Baltimore, 6/5/00, 3/15/01, by telephone 12/23/99, 7/26/00, 9/13/00, 10/9/00 & 11/3/00, by e-mail 1/17/00, 12/6/00, 1/15/01 & 3/28/02.
22. Schwartz, J. Sanford, M.D. Merion Station, PA, 11/6/00.
23. Gottlieb, Gary L., M.D. Boston, by telephone 6/19/00.
24. Ferniany, I. William, Ph.D. Philadelphia, 4/24/00.

25. DeAngelis Jr. Peter L. Philadelphia, 6/7/00, 11/13/00 by e-mail.
26. Jamieson, Kathleen Hall, Ph.D. Philadelphia, 3/23/01.
27. Mastroianni Jr., Luigi, M.D., 6/5/00, by telephone 12/19/00.
28. Stunkard, Albert J., M.D. Philadelphia, by telephone 9/29/00.
29. Williams, Gordon D. Durham, NC, by telephone 9/19/00.
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40. Emerson Jr., Charles P., Ph.D. Philadelphia, 6/16/00.
41. Marsh, Martha. Davis, CA, by telephone 9/29/00.
42. Ende, Jack, M.D. Philadelphia, 6/7/00.
43. Volpe, Michele M. Philadelphia, 6/7/00.
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63. Fox, Robert A. Jenkintown, PA, 12/1/00.

64. Foley, William T. Phoenix, by telephone 10/13/00.

65. Fry, John A. Philadelphia, 11/29/00.

66. Longnecker, David E., M.D. Philadelphia, 4/24/00, by telephone 9/28/00 & 2/20/01.

67. Holmes, Edward W., M.D. Durham, NC, by telephone 9/14/00.

68. Mennuti, Michael T., M.D. Philadelphia, 4/25/00.

69. Barchi, Robert L., M.D., Ph.D. Philadelphia, 10/6/00.

70. Seagrave, Richard E. Phoenixville, 6/29/00.

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73. Eisner, Joel W., M.D. Phoenixville, 6/29/00.

74. Catton, Raymond M., M.D. Phoenixville, 6/29/00.

75. McDonald, Walter J., M.D. Philadelphia, 10/13/00.

76. Barg, Ronald B., M.D. Philadelphia, 8/9/00, by telephone 10/13/00.

77. Kepner, John C. S., Esq. Philadelphia, 7/10/00.

78. Field, Robert I., Ph.D. Philadelphia, by telephone 10/30/00.

79. Beeman, Thomas. Nashville, by telephone 9/8/00.

80. Kelley, William N., M.D. Philadelphia, by telephone 7/12/01.

81. Williams, Sankey V., M.D. Philadelphia, 6/30/00.

82. Barchi, Robert L., M.D., Ph.D. Philadelphia, 5/11/01.

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88. Grippi, Michael A., M.D. Philadelphia, 6/30/00.

89. Stemmler, Edward J., M.D. Roseland, VA, by telephone 5/8/00 & 1/3/01.

90. George, Michael, Radnor, 6/29/00.

91. Josh Goldstein. "City hospitals eye the suburbs." *Philadelphia Inquirer*, 3/5/99, p. D01.

92. Henson, Douglas E. Philadelphia, 6/16/00, 11/30/00 by e-mail.
93. Parmacek, Michael S., M.D. Philadelphia, 10/6/00.
94. George, Michael, Radnor, 9/19/02 by e-mail.
95. Sussman, Elliot J., M.D. Allentown, PA, by telephone 6/9/00.
96. Barker, Clyde F., M.D. Philadelphia, 4/18/00.
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98. Harkins Jr., John G., Esq. Philadelphia, 10/21/00.
99. Rodin, Judith, Ph.D. Philadelphia, 5/11/01.
100. Colling, Dennis. Boston, by telephone 10/2/00.
101. Rodin, Judith, Ph.D. Philadelphia, by telephone 6/22/01.
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107. Black, Michael E. Philadelphia, 8/8/00.
108. Kelley, William N., M.D. Philadelphia, by telephone 4/16/01.
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120. Tannen, Richard L., M.D. Philadelphia, 4/24/00, by telephone 8/31/00.
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122. Williams, Henry C. Philadelphia, 6/16/00.
123. Matschinsky, Franz, M.D. Philadelphia, 6/5/00.
124. Schaffer, Priscilla A., Ph.D. Philadelphia, 8/8/00.
125. Kazazian Jr., Haig H., M.D. Philadelphia, 11/1/00.
126. Saunders, James C., Ph.D. Philadelphia, 11/1/00.
127. Fishman, Alfred P., M.D. Philadelphia, 8/7/00.
128. FitzGerald, Garret, M.D. Philadelphia, 8/9/00.

129. Baum, Stanley, M.D. Philadelphia, 4/18/00, by telephone 2/5/01.
130. Morrison, Gail, M.D. Philadelphia, 6/28/00.
131. Cox, Malcolm, M.D. Philadelphia, 8/7/00.
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133. Whittington, Marna C., Ph.D. West Conshohocken, PA, 10/5/00.
134. Burg, Frederic D., M.D. Huntsville, AL, by telephone 1/15/01.

CHAPTER FOUR: Kelley in Trouble

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6. Wyngaarden, James B., M.D. Durham, NC, by telephone 2/26/01.
7. Kazazian Jr., Haig H., M.D. Philadelphia, 11/1/00.
8. Laties, Alan M., M.D. Philadelphia, by telephone 9/29/00.
9. Nathanson, Neal, M.D. Philadelphia, by telephone 2/8/01.
10. Jarett, Leonard, M.D. Philadelphia, 4/25/00.
11. Davies, Helen Conrad, Ph.D. Philadelphia, 1/18/01.
12. Burg, Frederic D., M.D. Huntsville, AL, by telephone 1/15/01.
13. Catherwood, Susan W. Philadelphia, 11/29/00, by telephone 12/7/00.
14. Palmer, Russell E. Philadelphia, 11/30/00.
15. Langfitt, Thomas W., M.D. Philadelphia, 12/1/00.
16. Schwartz, J. Sanford, M.D. Merion Station, PA, 11/6/00.
17. Silberberg, Donald H., M.D. Philadelphia, 4/18/00, by telephone 9/11/00.
18. Williams, Henry C. Philadelphia, 6/16/00.
19. Gonatas, Nicholas K., M.D. Philadelphia, 11/5/00, by telephone 11/8/00 & 2/6/01.
20. Fagin, Claire M., Ph.D. New York, by telephone 10/1/00.
21. Matschinsky, Franz, M.D. Philadelphia, 6/5/00.
22. Holmes, Edward W., M.D. Durham, NC, by telephone 9/14/00.
23. McKenna, W. Gillies, M.D. Philadelphia, 10/4/00.
24. Morrison, Gail, M.D. Philadelphia, 6/28/00.
25. Mulhern, Victoria A. Philadelphia, by telephone 9/18/00.
26. Stunkard, Albert J., M.D. Philadelphia, by telephone 9/29/00.
27. Williams, Gordon D. Durham, NC, by telephone 9/19/00.
28. Yamada, Tadataka, M.D. King of Prussia, PA, by telephone 9/9/00.
29. Beeman, Thomas. Nashville, by telephone 9/8/00.

30. Saunders, James C., Ph.D. Philadelphia, 11/1/00.
31. Field, Robert I., Ph.D. Philadelphia, by telephone 10/30/00.
32. Barchi, Robert L., M.D., Ph.D. Philadelphia, 10/6/00.
33. Barker, Clyde F., M.D. Philadelphia, 4/18/00.
34. Baum, Stanley, M.D. Philadelphia, 4/18/00, by telephone 2/5/01.
35. Bryan, R. Nick, M.D., Ph.D. Philadelphia, 8/8/00.
36. Cox, Malcolm, M.D. Philadelphia, 8/7/00.
37. Dreyfuss, Gideon, Ph.D. Philadelphia, 10/6/00.
38. Emerson Jr., Charles P., Ph.D. Philadelphia, 6/16/00.
39. Foley, William T. Phoenix, by telephone 10/13/00.
40. Goodman, Robert L., M.D. Livingston, NJ, by telephone 9/29/00.
41. Hirshfeld, John W., M.D., 4/19/00.
42. Mennuti, Michael T., M.D. Philadelphia, 4/25/00.
43. Pitt, Bertram, M.D. Baltimore, 5/25/00.
44. Schaffer, Priscilla A., Ph.D. Philadelphia, 8/8/00.
45. Waxman, Harvey L., M.D. Philadelphia, 6/15/00.
46. Molinoff, Perry B., M.D. Wallingford, CT, by telephone 6/12/00.
47. Kissick, William L., M.D., 11/14/00.
48. Kelley, Mark A., M.D. Philadelphia, 4/25/00, by telephone 10/13/00.
49. Dutton, P. Leslie, Ph.D. Philadelphia, 8/8/00.
50. Burns, L. Robert, Ph.D. Philadelphia, 6/28/00.
51. Kelley, William N., M.D. Philadelphia, by telephone 4/16/01.
52. Bloom, Bernard S., Ph.D. Philadelphia, by telephone 2/21/01.
53. Williams, Sankey V., M.D. Philadelphia, 6/30/00.
54. FitzGerald, Garret, M.D. Philadelphia, 8/9/00.
55. Chance, Britton, Ph.D. Philadelphia, 6/7/00.
56. Fishman, Alfred P., M.D. Philadelphia, 8/7/00.
57. Mastroianni Jr., Luigi, M.D., 6/5/00, by telephone 12/19/00.
58. Whittington, Marna C., Ph.D. West Conshohocken, PA, 10/5/00.
59. Sussman, Elliot J., M.D. Allentown, PA, by telephone 6/9/00.
60. Tanenbaum, Myles H., Esq. West Conshohocken, PA, 11/30/00.
61. Kelley, William N., M.D. Philadelphia, by telephone 3/18/02 & 3/19/02.
62. Ferniany, I. William, Ph.D. Philadelphia, 4/24/00.
63. Tannen, Richard L., M.D. Philadelphia, 4/24/00, by telephone 8/31/00.
64. Wigglesworth, Andrew. Philadelphia, 1/18/01.
65. Daddis, John A. Philadelphia, 11/29/00.
66. DiBona Jr., G. F., Esq. Philadelphia, 11/29/00.
67. Zamzow, John C., Philadelphia, 11/29/00.
68. Owens, Gary M., M.D. Philadelphia, 11/29/00.
69. Marsh, Martha. Davis, CA, by telephone 9/29/00.

70. Karl Stark. "Hospital losses keep mounting. Nearly 60 percent in Phila. and almost half in its Pa. suburbs posted red ink in '99, a report found." *Philadelphia Inquirer*, 6/9/00, p. C01.

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72. Worley, Richard B. West Conshohocken, PA, 12/21/00.

73. Josh Goldstein. "When good intentions meet reality. Presbyterian foundation wanted to help the city's elderly. So it bought 6 nursing homes-and trouble." *Philadelphia Inquirer*, 6/21/00, p. D01.
74. Kepner, John C. S., Esq. Philadelphia, 7/10/00.
75. Vagelos, P. Roy, M.D. Bedminster, NJ, 12/20/00.
76. Van Dusen, Duncan W. Philadelphia, by telephone 11/10/00 & 11/17/00.
77. Fox, Robert A., Jenkintown, PA, 12/1/00.
78. Goodman, David B. P., M.D., Ph.D. Philadelphia, 10/6/00.
79. Scheib, Garry L. Philadelphia, 6/30/00, by telephone 9/27/00.
80. Marian Uhlman. "Hospital deal: just business. In picking Penn Health, Pennsylvania Hospital forsook Jefferson neighborhood ties." *Philadelphia Inquirer*, 11/14/96, p. D01.
81. Welsh, Raymond H. Philadelphia, 12/1/00, by telephone 12/11/00.
82. Harris, C. Martin, M.D. Cleveland, by telephone 9/21/00.
83. Brown Jr., Richard P., Esq. Philadelphia, by telephone 2/27/01.
84. Parmacek, Michael S., M.D. Philadelphia, 10/6/00.
85. Rosengard, Bruce R., M.D. Philadelphia, by telephone 11/10/00.
86. Blutt, Mitchell J., M.D. New York, by telephone 1/19/01.
87. Barg, Ronald B., M.D. Philadelphia, 8/9/00, by telephone 10/13/00.
88. Otten, Jeffrey. Boston, by telephone 9/20/00.
89. Fry, John A. Philadelphia, 11/29/00.
90. Kerr, Gavin. King of Prussia, PA, by telephone 10/9/00.
91. Colling, Dennis. Boston, by telephone 10/2/00.
92. Volpe, Michele M. Philadelphia, 6/7/00.
93. Lavizzo-Mourey, Risa, M.D. Princeton, by telephone 5/9/01.
94. DeAngelis Jr. Peter L. Philadelphia, 6/7/00, 11/13/00 by e-mail.
95. Notebaert, Edmond F. Philadelphia, 1/5/00.
96. Kelley, William N., M.D. Philadelphia, by telephone 7/12/01.
97. Kelley, William N., M.D. Philadelphia, by telephone 7/26/01.
98. Rodin, Judith, Ph.D. Philadelphia, 11/6/00.
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100. Evans, Dwight L., M.D. Philadelphia, 10/5/00.
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102. Gorenstein, William. Philadelphia, 8/7/00.
103. Harold Brubaker. "Penn Health led the way in leaders' pay for 1998–99 at 62 area hospitals and medical centers. The median increase was 6.9%, more than twice the rate of inflation." *Philadelphia Inquirer*, 10/22/00, p. E01.
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105. Stinnett, James L., M.D. Philadelphia, by telephone 6/21/00.
106. Shea J. Spearheads of a movement. *Penn Medicine*. Spring, 1999:14–18.
107. Peter T. Kilborn. "Manager of care, not of costs." *New York Times*, 12/7/98.
108. Rogers, Paul H., M.D. Phoenixville, by telephone 10/3/00.
109. Jacobson, Gerald J. Wyncote, PA, by telephone 9/28/00.
110. Bowman, Marjorie A., M.D. Philadelphia, 6/15/00.
111. Strom, Brian L., M.D. Philadelphia, 6/28/00.

112. Andrea Knox. "Penn system recovering much faster than expected. The hospital and health system group has trimmed losses significantly and expects to be profitable this year." *Philadelphia Inquirer*, 9/15/00, p. A01.

113. Adler, Betty S., Esq. Philadelphia, 10/5/00.

114. Miller Jr., Paul F. West Conshohocken, PA, 1/18/01.

115. Henson, Douglas E. Philadelphia, 6/16/00, 11/30/00 by e-mail.

116. Black, Michael E. Philadelphia, 8/8/00.

117. Harkins Jr., J. G., Esq., Philadelphia, 10/21/00.

118. Longnecker, David E., M.D. Philadelphia, 4/24/00, by telephone 9/28/00 & 2/20/01.

119. Karl Stark. "Faculty prevails; no split at Penn. A plan discussed by the trustees would have separated the health system from the university." *Philadelphia Inquirer*, 2/13/00, p A01.

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134. Goldfarb, Stanley, M.D. Philadelphia, 4/18/00, by telephone 10/30/00.

135. Gross, Larry, Ph.D. Philadelphia, by telephone 10/10/2000.

136. Langenberg, Donald N., Ph.D. Baltimore, 10/11/00.

137. Ball, John R., M.D. Havre de Grace, MD, 5/13/00.

138. Quinn, Peter D., M.D. Philadelphia, by telephone 3/19/01.

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147. Burbank, Stephen B., Esq. Philadelphia, 9/19/00 by telephone.

148. Jodi Wilgoren. "First woman to lead Ivy League college is the highest paid university president." *New York Times*, 11/19/00.

149. "Clearing the record." *Philadelphia Inquirer*, 8/23/00, p. A04.

150. Piper, Arthur H. Philadelphia, 6/15/00.

151. Kelley, William N., M.D. Philadelphia, by telephone 7/30/01.

152. Rodin, Judith, Ph.D. Philadelphia, 5/11/01.

153. Fry, John A. Philadelphia, by e-mail 6/21/01.

154. Fagin CM. Author profile: about Claire Fagin. In: Fagin,CM, editor. *Essays on Nursing Leadership*. New York: Springer; 2000:chapter 1, 1–28.

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158. Rodin, Judith, Ph.D. Philadelphia, by telephone 6/22/01.

159. Fry, John A. Philadelphia, 5/11/01.

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160. Karl Stark. "Medical staff at Penn fears more big cuts. With the chief executive officer and two lieutenants gone, insecurities run deep. Some feel it's time to restructure." *Philadelphia Inquirer*, 3/6/00, p. C01.

161. Hackney, Sheldon, Ph.D. Martha's Vineyard & Philadelphia, by telephone 6/2/00.

162. Katz, Gerald. Plymouth Meeting, PA, 12/21/00.
163. Altschuler, Steven M., M.D. Philadelphia, 6/30/00.
164. Milt Freudenheim. "Bitter pills for Aetna: Is its approach dated?" *New York Times*, 7/22/00.
165. Kelley, William N., M.D. Philadelphia, by telephone 4/2/01.
166. Reinhardt, Uwe, Ph.D. Princeton, by telephone 11/10/99.
167. Pauly, Mark V., Ph.D. Philadelphia, 6/16/00.

CHAPTER FIVE: After Kelley

1. "Business news in brief." *Philadelphia Inquirer*, 3/17/00, p. CO3.
2. Traber, Peter G., M.D. Philadelphia, 4/25/00.
3. Matschinsky, Franz, M.D. Philadelphia, 6/5/00.
4. Asbury, Arthur K., M.D. Philadelphia, by telephone 7/31/01.
5. Buckley, R. Michael, M.D. Philadelphia, 6/16/00.
6. George, Michael. Radnor. 6/29/00.
7. Barg, Ronald B., M.D. Philadelphia, 8/9/00, by telephone 10/13/00.
8. Kelley, William N., M.D. Philadelphia, by telephone 3/18/02 & 3/19/02.
9. Goodman, David B. P., M.D., Ph.D. Philadelphia, 10/6/00.
10. Van Dusen, Duncan W. Philadelphia, by telephone 11/10/00 & 11/17/00.
11. Henson, Douglas E. Philadelphia, 6/16/00, 11/30/00 by E-mail.
12. Kelley, William N., M.D. Philadelphia & Baltimore, 6/5/00, 3/15/01, by telephone 12/23/99, 7/26/00, 9/13/00, 10/9/00 & 11/3/00, by e-mail 1/17/00, 12/6/00 & 1/15/01.
13. Kissick, William L., M.D., 11/14/00.
14. Goodman, Robert L., M.D. Livingston, NJ, by telephone 9/29/00.
15. Piper, Arthur H., Philadelphia, 6/15/00.
16. Wigglesworth, Andrew. Philadelphia, 1/18/01.
17. Williams, Sankey V., M.D. Philadelphia, 6/30/00.
18. Mennuti, Michael T., M.D. Philadelphia, 4/25/00.
19. Ferniany, I. William, Ph.D. Philadelphia, 4/24/00.
20. Karl Stark. "In Phoenixville, a flare-up over Penn health." *Philadelphia Inquirer,* 12/26/99, p. D01.
21. Catton, Raymond M., M.D. Phoenixville, 6/29/00.
22. Christopher Merrill. "Phoenixville hospital downsizes; cut workers can reapply. Sixteen jobs will go, to reduce the budget. Some other jobs remain open; the displaced may fill them." *Philadelphia Inquirer*, 10/28/99, p. B03.
23. Seagrave, Richard E. Phoenixville, 6/29/00.
24. Eisner, Joel W., M.D. Phoenixville, 6/29/00.
25. McDonald, Walter J., M.D. Philadelphia, 10/13/00.
26. Kepner, John C. S., Esq. Philadelphia, 7/10/00.
27. Harris, C. Martin, M.D. Cleveland, by telephone 9/21/00.
28. Rogers, Paul H., M.D. Phoenixville, by telephone 10/3/00.
29. Schwartz, J. Sanford, M.D. Merion Station, PA, 11/6/00.
30. Karl Stark. "Medical staff at Penn fears more big cuts. With the chief executive officer and two lieutenants gone, insecurities run deep. Some feel it's time to restructure." *Philadelphia Inquirer*, 3/6/00, p. C01.

31. Williams, Gordon D. Durham, NC, by telephone 9/19/00.
32. Black, Michael E. Philadelphia, 8/8/00.
33. Carnarole, Craig R. Philadelphia, 5/11/01.
34. Andrea Knox. "Penn Health's CEO resigns." *Philadelphia Inquirer*, 7/27/00.
35. Yamada, Tadataka, M.D. King of Prussia, PA, by telephone 9/9/00.
36. Schaffer, Priscilla A., Ph.D. Philadelphia, 8/8/00.
37. FitzGerald, Garret, M.D. Philadelphia, 8/9/00.
38. Palmer, Russell E. Philadelphia, 11/30/00.
39. Tannen, Richard L., M.D. Philadelphia, 4/24/00, by telephone 8/31/00.
40. Tanenbaum, Myles H., Esq. West Conshohocken, PA, 11/30/00.
41. Rodin, Judith, Ph.D. Philadelphia, by telephone 6/22/01.
42. Rodin, Judith, Ph.D. Philadelphia, 11/6/00.
43. Barchi, Robert L., M.D., Ph.D. Philadelphia, 5/11/01.
44. Fox, Robert A. Jenkintown, PA, 12/1/00.
45. Kelley, William N., M.D. Philadelphia, by telephone 7/26/01.
46. Bryan, R. Nick, M.D., Ph.D. Philadelphia, 8/8/00.
47. Dutton, P. Leslie, Ph.D. Philadelphia, 8/8/00.
48. Emerson Jr., Charles P., Ph.D. Philadelphia, 6/16/00.
49. Andrea Knox. "Hospital officials' selection draws ire. Penn Health appointed the two top managers in Phoenixville without consulting the staff." *Philadelphia Inquirer*, 9/29/00, p. C01.
50. Goldfarb, Stanley, M.D. Philadelphia, 4/18/00, by telephone 10/30/00.
51. Rodin, Judith, Ph.D. Philadelphia, 5/11/01.
52. Katz, Gerald. Plymouth Meeting, PA, 12/21/00.
53. Vagelos, P. Roy, M.D. Bedminster, NJ, 12/20/00.
54. Evans, Dwight L., M.D. Philadelphia, 10/5/00.
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58. Blutt, Mitchell J., M.D. New York, by telephone 1/19/01.
59. Riepe, James S. Baltimore, 2/12/01.
60. Ball, John R., M.D. Havre de Grace, MD, 5/13/00.
61. Josh Goldstein. "Penn says it won't sell its hospitals. A new nonprofit corporation will run the health system. Questions remain about the university's debt liabilities." *Philadelphia Inquirer*, 2/17/01.
62. Judith Rodin, by e-mail 2/16/01.
63. Fry, John A. Philadelphia, 5/11/01.
64. Catherwood, Susan W. Philadelphia, 11/29/00, by telephone 12/7/00.
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69. Joshua Runyan. "Doctors mull future plans for Health System. Faculty are glad to see the Medical School keep its center for teaching." *Daily Pennsylvanian*, 2/22/01.

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71. Nemzoff, Joshua A. New Hope, PA, by telephone 2/22/01.

72. Fry, John A. Philadelphia, 11/29/00.

73. Josh Goldstein. "Penn hires health-care veteran for transition." *Philadelphia Inquirer*, 7/31/01.

74. Rodin J, Barchi RL. Arthur Rubenstein appointed EVP and Dean. 7/30/2001.

75. Rubenstein, Arthur H., M.B., B.Ch. Philadelphia, 2/25/02.

76. Kelley, William N., M.D. Philadelphia, by telephone 8/1/01.

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80. Henson, Douglas E. Philadelphia, by telephone 6/20/02.

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CHAPTER SIX: Separate Governance

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3. Chesney AM. *The Johns Hopkins Hospital and The Johns Hopkins University School of Medicine. A Chronicle*. Vol. I. *Early Years 1867–1893*. Baltimore: Johns Hopkins University Press; 1943.

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18. Flexner S, Flexner JT. *William Henry Welch and the Heroic Age of American Medicine*. Baltimore: Johns Hopkins University Press; 1993:217.

19. Johns, Richard J., M.D. Baltimore, by telephone 3/7/02.

20. Peterson, Ronald R. Baltimore, by e-mail 5/20/02.

21. Peterson, Ronald R. Baltimore, by telephone 5/24/02.

22. Turner TB. *Heritage of Excellence. The Johns Hopkins Medical Institutions, 1914–1947*. Baltimore: Johns Hopkins University Press; 1974:76.

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24. Ross, Richard S., M.D. Sanibel, FL, by e-mail 4/11/02.

25. Turner TB. *Heritage of Excellence. The Johns Hopkins Medical Institutions, 1914–1947*. Baltimore: Johns Hopkins University Press; 1974:520.

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28. Mountcastle, Vernon B., M.D. Baltimore, by telephone 4/18/02.

29. Gibson RE, Johns RJ. A study of the management of the Johns Hopkins Medical School and the Johns Hopkins Hospital. 1971.

30. Michael Ollove. "Johns Hopkins Hospital: the board to be on." *Baltimore Sun*, 2/17/91.

31. Blake, David A., Ph.D. Atlanta, 12/17/01.

32. McGuirk Jr., William E. Churchville, MD, 10/22/01.

33. Ross, Richard S., M.D. Baltimore, by e-mail 4/23/02.

34. Bloomberg, Michael R. New York, 12/28/01.

35. Dunn Jr., Edward K. Baltimore, 10/16/01.

36. Brewster, Andre W., Esq. Baltimore, 10/29/01.
37. Zamoiski Jr., Calman J. Baltimore, by telephone 5/2/02.
38. Richardson, William C., Ph.D. Battle Creek, MI by telephone 12/3/01.
39. Pollak, Joanne E., Esq. Baltimore, 10/2/01.
40. Stiller, Shale D., Esq. Baltimore, 11/19/01.
41. Sunshine, Eugene S. Evanston, IL, by telephone 12/11/01.
42. Baldwin, H. Furlong. Baltimore, 10/23/01.
43. Offit, Morris W. New York, 9/25/01.
44. Richardson, William C., Ph.D. Battle Creek, MI, by telephone 4/2/02.
45. Ross, Richard S., M.D. Sanibel, FL, by e-mail 4/18/02.
46. Baldwin, H. Furlong. Baltimore, by telephone 3/11/02.
47. Muller, Steven, Ph.D. Washington, 5/16/00.
48. McKhann, Guy M. Baltimore, 7/5/01.
49. Sommer, Alfred, M.D. Baltimore, 10/24/01.
50. Heyssel, Robert M., M.D. Seaford, DE, 5/4/01.
51. Bunting Jr., George L. Timonium, MD, 10/29/01.
52. Bunting Jr., George L. Boca Grande, FL, by telephone 1/11/02.
53. Long, Donlin M., M.D., Ph.D. Baltimore, 1/3/02.
54. Ross RS. Governance of the Johns Hopkins Medical Institutions. 1989.
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CHAPTER SEVEN: Unified Governance

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CHAPTER EIGHT: Conclusions

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Appendix 1: Governance of American Academic Medical Centers

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